

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02296

2324

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52</u> TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>X</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14</u> <u>Spring Grove State Hosp.</u>				STREET ADDRESS (If rural give location) <u>Baltimore County Home</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>Eli</u>		(Middle)		(Last) <u>Albans</u>	
4. DATE OF DEATH:		(Month) <u>3</u>		(Day) <u>24</u>		(Year) <u>19 55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>6-1-1878</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>USA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>unknown Eli S. Alban.</u>				14. MOTHER'S MAIDEN NAME: <u>unknown Elizabeth Bull.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no record</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS: <u>Hospital's records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>422.1</u> <u>Cerebral vascular accident</u>						<u>3 days</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerotic cardio-vascular disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 23, 19 55</u> to <u>3-24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-24</u> , 19 <u>55</u> , and that death occurred at <u>12:15 P</u> M, from the causes and on the date stated above.							
SIGNATURE <u>B. Wachler</u>		M. D. <u>Spring Grove St. Hospital</u>		DATE SIGNED <u>3/28/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 26, 19 55</u>		NAME OF CEMETERY OR CREMATORY <u>Pine Grove Cemetery</u>		LOCATION (City, town, or county) (State) <u>Parkton, Balto. Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/24/55</u>		REGISTRAR'S SIGNATURE <u>T.E. Harry</u>		24. FUNERAL DIRECTOR <u>J. Jacobson</u>		ADDRESS <u>New Freedom, Pa.</u>	

BUREAU V. S.

MAR 29 1935

RECEIVED

2310

02297

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No. 41

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTE.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>DUNDALK</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3218 MCSHAHANE WAY</u>		STREET ADDRESS (If rural, give location) <u>3218 MCSHAHANE WAY</u>	
3. NAME OF DECEASED (Type or Print) <u>ELIZABETH ANN AMOS</u>	4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>29</u> (Year) <u>1955</u>		
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>MAY 5, 1877</u>
9. AGE last birthday <u>77</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>AT HOME</u>	11. BIRTHPLACE (State or foreign country) <u>OHIO</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>PICKENS</u>	14. MOTHER'S MAIDEN NAME <u>BELLE LAINE</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>	16. SOCIAL SECURITY No. <u>-</u>	17. INFORMANT AND ADDRESS <u>HOWARD W. AMOS 4412 BEALL ST. LINDSEY HILLS MD</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) <u>443X Immediate cause</u> <u>Hypertensive Cardio-Vascular Disease</u>		
(b) <u>Antecedent cause(s)</u> <u>Disease</u>		
(c) <u>Other</u>		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>none</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or office, etc.) OF INJURY <u>Office</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE M. J. Dore (Degree or title) Sup. Med Exam - Dundalk rr. Md ADDRESS 4412 BEALL ST. LINDSEY HILLS MD DATE SIGNED 3/30/55

23. RIAL CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>APR 4, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>	LOCATION (City, town, or county) <u>COLGATE MD</u>
DATE REC'D BY LOCAL REG. <u>March 31-1955</u>	REGISTRAR'S SIGNATURE <u>William M. Kelly</u>	24. FUNERAL DIRECTOR <u>ULLRICH FUNERAL HOME</u>	ADDRESS <u>2112 DUNDALK</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 4 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2325

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02298

CERTIFICATE OF DEATH

Reg. Dist. No.....

Items 12, 13, 14 FilmG179 3-18-55 et

1. PLACE OF DEATH COUNTY Balto. Co. Md. MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY			
CITY (If outside corporate limits, write RURAL and OR give nearest town) X TOWN Logan Village				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Balto. City 3Y01-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3492 Logan View WA.Y				STREET ADDRESS (If rural, give location) 1401 Filbert St.			
3. NAME OF DECEASED (Type or Print)		(First) Elizabeth Bagdan		(Middle) (Bagdoniene)		(Last)	
6. SEX Female		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, Widowed		4. DATE OF DEATH Mar. 10, 55 19	
8. DATE OF BIRTH 1874		9. AGE last birthday 81 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		11. BIRTHPLACE (State or foreign country) Lithuania	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16. SOCIAL SECURITY No. -		17. INFORMANT AND ADDRESS Nellie Salkoski 4201 Grace Ct.	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
578X Immediate cause (a) massive Intestinal Hemorrhage						4 days	
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)				PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY				INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 5 Mar. 1955 to 10 Mar. 1955 , that I last saw the deceased alive on 10 Mar. 1955 , and that death occurred at 7:00 P m., from the causes and on the date stated above.							
SIGNATURE M. D. 3 Kinsbury Rd. Balt. Md				DATE SIGNED 12 Mar 55			
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		3-15-55		Holy Cross		A.A. C.P. Md.	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS			
3/14/55		Q. W. H. [Signature]		Wm. S. Fialkowski 2007 Eastern Ave.			

RK



2311

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>53 Dundalk</u>		LENGTH OF STAY (in this place) <u>3 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>53 Dundalk</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7731 Fairgreen Road</u>				STREET ADDRESS (If rural give location) <u>7731 Fairgreen Road</u>			
3. NAME OF DECEASED: (First) <u>Effie</u>		(Middle) <u>Miller</u>		(Last) <u>Bailey</u>		4. DATE OF DEATH: (Month) <u>March</u> (Day) <u>29th</u> (Year) <u>1955</u>	
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>10/4/89</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Home</u>		11. BIRTHPLACE (State or foreign country): <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Marcus Miller</u>				14. MOTHER'S MAIDEN NAME: <u>Sally Lester</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs. Raymond Dowdy, 7731 Fairgreen Rd. Dundalk, Md.</u>			

18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
<u>260X</u> Immediate cause (a) <u>Coronary Thrombosis</u>				<u>10 min.</u>			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Myocarditis</u>				<u>1 month</u>			
(c) <u>Diabetes Mellitus</u>				<u>5 years</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY ? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			
22. I hereby certify that I attended the deceased from <u>the</u> 19 <u>54</u> , to <u>March 29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 29</u> , 19 <u>55</u> , and that death occurred at <u>1957</u> , from the causes and on the date stated above.							
SIGNATURE <u>David H. Andrew</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>33 Dundalk Ave</u>		DATE SIGNED <u>3/29/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>4/2/55</u>		<u>Woodlawn Cemetery</u>		<u>Ironton, Ohio</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>March 29-1955</u>		<u>William M. Kelly</u>		<u>Walter Branch Bradley, Inc.</u>		<u>Dundalk, Md.</u>	

MARGIN RESERVED FOR BINDING

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BUREAU V. S.

APR 1 1964

RECEIVED

02300

2326

MARYLAND STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 37

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lutherville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lutherville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Railroad Avenue</u>		STREET ADDRESS (If rural, give location) <u>Railroad Avenue</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>WILLIAM WALTER BAKER</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 5, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>July 10, 1880</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>School Dept.</u>	9. AGE last birthday <u>74</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Walter Baker</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Baker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>None</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Family Information</u>			

18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.1</u> Immediate cause (a) <u>Heart disease - coronary occlusion</u> Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u> (c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>William C. Hudson M.D., D.M.E.</u>		DATE SIGNED <u>3/7/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Mar. 8, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>
LOCATION (City, town, or county) <u>Towson, Maryland</u>		(State) <u>Md.</u>	
DATE REC'D BY LOCAL REG. <u>March 1955</u>		24. FUNERAL DIRECTOR <u>John Burns & Sons</u>	
REGISTRAR'S SIGNATURE <u>Anne Annis MacRae</u>		ADDRESS <u>Towson, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. M.

MAR 10 1955

RECEIVED

2327

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Balto.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>21 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Reisterstown</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>46 Bond Avenue</u>		/	
3. NAME OF DECEASED: (Type or Print) <u>REYNOLDS</u>		(First) <u>H.</u> (Middle) <u>BALTIMORE</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>March 23 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>October 6, 1887</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Truck Driver</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Cement Company</u>		11. BIRTHPLACE (State or foreign country): <u>Front Royal, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Turner Baltimore</u>				14. MOTHER'S MAIDEN NAME: <u>Martha MN: Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW-I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Clin.Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>MYOCARDIAL INFARCTION</u>						2 WEEKS	
ANTECEDENT CAUSE (S) DUE TO <u>CORONARY THROMBOSIS</u>						2 WEEKS	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M.		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 2, 1955</u> , to <u>Mar. 23, 1955</u> , that I observed the deceased <u>and that death occurred at 12:15 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William B. VandeGrift, M.D.</u>		DATE THEREOF <u>3/27/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Perney Grove Cemetery</u>		LOCATION (City, town, or county) (State) <u>Boring, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/27/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Perney Grove Cemetery</u>		LOCATION (City, town, or county) (State) <u>Boring, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>March 26, 1955</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>		24. FUNERAL DIRECTOR <u>Arlington S. Phillips Funeral Home</u>		ADDRESS <u>1808 N. Monroe St. Baltimore 17, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Delivered by Hearse by Phillips Funeral Home

2328

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 TOWN Catonsville		LENGTH OF STAY (in this place) 2yr. 10mo. 8days		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore		3Y 01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hospital				STREET ADDRESS (If rural give location) 338 S. Mount Street ✓			
3. NAME OF DECEASED: (Type or Print) Sarah		(First) (Middle) Haron		(Last) Barber		4. DATE (Month) (Day) (Year) OF DEATH: March 9, 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): Widowed	8. DATE OF BIRTH: 8-22-1892	9. AGE last birthday: 62	10. IF UNDER 1 YEAR Months	11. IF UNDER 1 YEAR Days	12. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Maryland	
13. FATHER'S NAME: Michael Haron				12. CITIZEN OF WHAT COUNTRY? USA			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. Unknown		17. INFORMANT & ADDRESS: Records Spring Grove State Hospital	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
443X IMMEDIATE CAUSE (A) Cardiac failure DUE TO		1 day
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(B) Hypertensive c.v. disease DUE TO		Years
(C) Uremia		1 week ✓

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Generalized arteriosclerosis		Years
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19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
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21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
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22. I hereby certify that I attended the deceased from 5-1-1952, to 3-9-1955, that I last saw the deceased alive on 3-9-1955, and that death occurred at 10:30 AM, from the causes and on the date stated above.

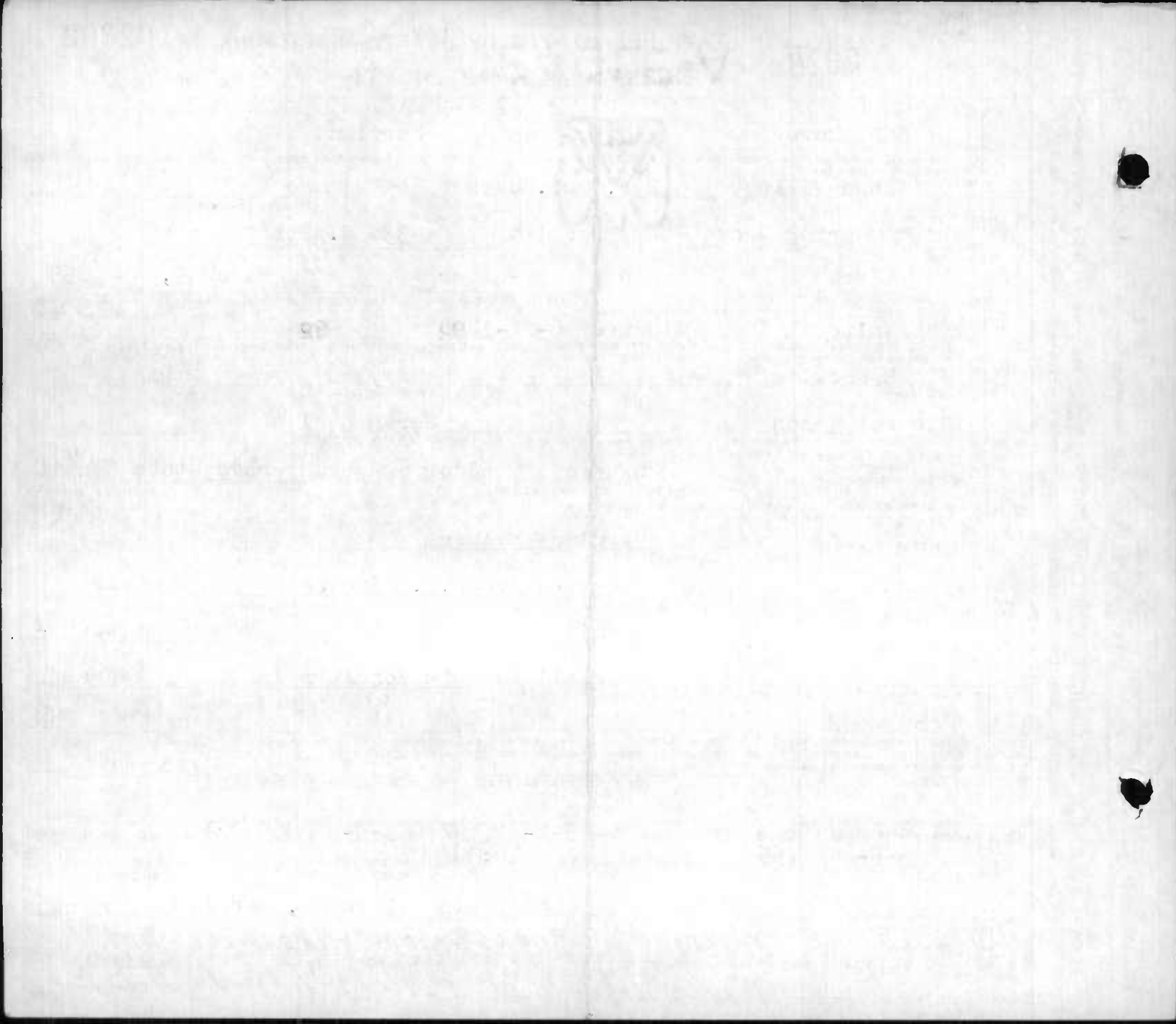
SIGNATURE S. Wachter M. D. Catonsville 28, Maryland 3-9-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	DATE THEREOF 3-17-1955	NAME OF CEMETERY OR CREMATORY CHARLES CEM. Pikesville Md	LOCATION (City, town, or county) (State)
---	------------------------	--	--

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE R. W. Hedrick	24. FUNERAL DIRECTOR H. B. Walters
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MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2329

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN Cockeysville

LENGTH OF STAY (in this place)
28 yrs.

HOSPITAL OR INSTITUTION OR

STREET ADDRESS Powers Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland

COUNTY Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Cockeysville

STREET ADDRESS

(If rural give location)

Powers Avenue

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

JAMES

CORNELIUS

BARBOUR

4. DATE OF DEATH:

(Month)

(Day)

(Year)

March 10,

19 55

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

Male

White

Married

Sept. 29, 1875

79

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

Pharmacist

10b. KIND OF BUSINESS OR INDUSTRY:

Retail Druggist

11. BIRTHPLACE (State or foreign country):

Kentucky

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME:

Lewis Coleman Barbour

14. MOTHER'S MAIDEN NAME:

Elizabeth Ann Ford

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

None

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Family Records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

422.2
Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb. 1948, to March 1955, that I last saw the deceased alive on March 9, 1955 and that death occurred at 1:30 P.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

Burial

Mar. 12, 1955

Poplar Methodist Cemetery

Cockeysville, Maryland

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

14 March 1955 - Ann Unistead MacRae

John Burns' Sons,

Towson, Md.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 16 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02304
2330 CERTIFICATE OF DEATH

Reg. Dist. No. 44...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>22 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1112 Ramblewood Road</u>			
3. NAME OF DECEASED: (First) <u>HARRY</u>		(Middle) <u>E.</u>		(Last) <u>BENSON</u>		4. DATE (Month) (Day) (Year) OF DEATH <u>March 13, 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>3-26-94</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Merchant</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Tobacco Store</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William H. Benson</u>				14. MOTHER'S MAIDEN NAME: <u>Laura Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Fort Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CARCINOMA OF PROSTATE WITH METASTASIS TO</u>						UNKNOWN	
ANTECEDENT CAUSE (B) <u>THORACIC 4TH VERTEBRA</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>3-8-55</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Excision of Extradural Metastasis, Level T4</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 19, 1955</u> to <u>March 13, 1955</u> and that death occurred at <u>3:55 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. Vandegrift, M.D.</u>		M.D. VAH, FORT HOWARD, MARYLAND		DATE SIGNED <u>3-11-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-17-55</u>		NAME OF CEMETERY OR CREMATORY <u>Louden Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <u>William J. Tickner & Sons, Inc.</u> ADDRESS <u>North and Pennsylvania Ave., Baltimore, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

STANDARD STATE DEPARTMENT OF HEALTH - BUREAU OF HEALTH
CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Signature of physician: _____
10. Signature of registrar: _____
11. Date of registration: _____

THIS CERTIFICATE IS TO BE FILED IN THE DEPARTMENT OF HEALTH, BUREAU OF HEALTH, AND IN THE COUNTY CLERK'S OFFICE, AND IN THE CITY CLERK'S OFFICE, IF THE DECEASED WAS A RESIDENT OF THE CITY.

RECEIVED BY THE DEPARTMENT OF HEALTH

2331

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town.) <u>Wiltondale</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town.) <u>Wiltondale</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>600 Yarmouth Road</u>				STREET ADDRESS (If rural give location) <u>600 Yarmouth Road #4</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mrs. Carrie Holland Berger</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>March 11 19 55</u>			
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Nov. 12, 1891</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Mln.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Inspector Oles Envelope</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>Mr. Charles Holland</u>				14. MOTHER'S MAIDEN NAME: <u>? Schmidtke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-24-1621</u>		17. INFORMANT & ADDRESS: <u>Mr. Ernest Berger, 600 Yarmouth Road #4</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>							
ANTECEDENT CAUSE (S) (B) <u>Renal Disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Chronic Trauma</u>						3 mos	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 10, 1955</u> , to <u>March 11, 1955</u> , that I last saw the deceased alive on <u>March 10, 1955</u> , and that death occurred at <u>1047 M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Albert C. Sikorsky</u>				ADDRESS <u>5939 Mc Elroy St</u>		DATE SIGNED	
M. D. <u>March 11, 1955</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 14, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE RECEIVED BY LOCAL REGISTRAR <u>March 14, 1955</u>		REGISTRAR'S SIGNATURE <u>John J. Ruck</u>		24. FUNERAL DIRECTOR <u>Leonard J. Ruck</u>		ADDRESS <u>5365 Harford Road #14</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Albert Sikorsky
2939 Mc Elderry Street
Br. 6 1234

2332

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) None LENGTH OF STAY (in this place) 26 yrs
TOWN None
HOSPITAL OR INSTITUTION OR STREET ADDRESS Mt Zion

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) None OR TOWN None
STREET ADDRESS (If rural, give location) Mt Zion

3. NAME OF DECEASED: (Type or Print)

(First)

(Middle)

(Last)

4. DATE OF DEATH:

(Month)

(Day)

(Year)

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

422.1

Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(c)

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while working ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 38, 1955, to March 14, 1955, that I last saw the deceased alive on March 5, 1955, and that death occurred at 10:30 P.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, OR REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(STATE)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3-16-55 Mary B. Eline Wm. B. Bryman & Sons Reisterstown

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Handwritten text, possibly "Handwritten text"

Handwritten text, possibly "Handwritten text"

BUREAU V. S.

MAR 17 1965

RECEIVED

Handwritten text, possibly "Handwritten text"

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2333

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02307w

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>9.9.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Lanhamville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rosalia</u> 02X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Caton Ridge Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>Long Point</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>William</u> <u>Bertie</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March</u> <u>28</u> <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married Nov 13-1945</u>	8. DATE OF BIRTH <u>Nov 13-1945</u>
9. AGE last birthday <u>89</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Householder</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>P. ?</u>		14. MOTHER'S MAIDEN NAME <u>P. ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Raymond Bertie Belair, Rd., Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH <u>6 hr.</u>
Immediate cause <u>331X</u> (a) <u>Cerebral hemorrhage</u>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Cerebral arteriosclerosis</u> (c) <u>Generalized arteriosclerosis</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arterioscl. C-V Dis. Parkinsonism</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Oct., 1954, to March 28 1955, that I last saw the deceased alive on March 8, 1955, and that death occurred at 1—P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>March 31-1955</u>	NAME OF CEMETERY OR CREMATORY <u>Capitol Hill</u>	LOCATION (City, town, or county) (State) <u>Baltimore - Md</u>
DATE REC'D BY LOCAL REG. <u>3-29-55</u>	REGISTRAR'S SIGNATURE <u>John Hedrick</u>	24. FUNERAL DIRECTOR <u>C. H. Bowman Evans</u>	ADDRESS <u>14005 Charles St Baltimore 30 Md</u>

Dr - Krumboltz -

400 N - Hilton

Wi - 5 - 7083

2334

CERTIFICATE OF DEATH

Reg. Dist. No. 22

1. NAME OF DECEASED (Type or Print) EVA MAY BLAKE			2. DATE OF DEATH MARCH 31 1955		
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore County			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE COUNTY		
B. FULL NAME OF HOSPITAL OR INSTITUTION X			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) RURAL BRIGHTON, MD		
C. Length of stay in Baltimore 58 Yrs. 00 Mos. 00 Days			D. STREET ADDRESS (If rural, give location) 6509 FAIRMOUNT AVE. BALT.		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED	8. DATE OF BIRTH APRIL 22, 1904	9. AGE (In years last birthday) 50	10. Under 1 Year Months: Days Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE			10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME EDWARD WINK			14. MOTHER'S MAIDEN NAME ELLEN BROWN		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO			16. SOCIAL SECURITY NO.		17. INFORMANT VINCENT DE PAUL BLAKE
18. 416X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) Rheumatic C. V. Disease			INTERVAL BETWEEN ONSET AND DEATH About 35 yrs		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) (B) (C)			CAUSE OF DEATH Rheumatic C. V. Disease		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from March 31 1955 to March 29 1955 , and that death occurred at 2:25 p.m. , from the causes and on the date stated above.					
23A. SIGNATURE Julius C. Bluck M.D.		23B. ADDRESS 5356 Reisterstown Rd		23C. DATE SIGNED 3/31/55	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 4-2-55		24C. NAME OF CEMETERY OR CREMATORY David Ridge	
24D. LOCATION (City, town, or county) (State) P. Nesville Md		25. FUNERAL DIRECTOR FRANK H. NEWELL		ADDRESS Pikesville Md	
DATE RECEIVED BY LOCAL REGISTRAR March 31 1955		REGISTRAR'S SIGNATURE Harold A. Newell		25. FUNERAL DIRECTOR FRANK H. NEWELL	

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WRITE PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be fully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE FILED IN THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

2335 CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE MARYLAND	COUNTY BALTO
CITY (If outside corporate limits, write RURAL and give nearest town) RURAL BALTIMORE	LENGTH OF STAY (in this place) 6 YRS	CITY (If outside corporate limits, write RURAL and give nearest town) RURAL BALTIMORE	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 3521 TULSA RD BALTO 7 MD		STREET ADDRESS (If rural give location) 3521 TULSA RD. BALTO. 7, MD	
3. NAME OF DECEASED: (First) VICTORIA (Middle) L. (Last) BLUM		4. DATE OF DEATH: (Month) MARCH (Day) 25 (Year) 1955	
5. SEX: F	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED	8. DATE OF BIRTH: JAN 13, 1913
9. AGE last birthday: 42 yrs.		10. MONTHS 4 DAYS 1 HOURS 1 MIN.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? US	
13. FATHER'S NAME: Jacob Kadbluski		14. MOTHER'S MAIDEN NAME: -----	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: ALFRED CLAYTON BLUM		3521 TULSA RD BALTO 7, MD	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death
Immediate cause (a) GENERALIZED CARCINOMATOSIS			6 MOS.
Antecedent causes (s) (b) CARCINOMA OF OVARY			1 1/2 YRS
(c)			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: 31 JAN 55		19b. MAJOR FINDINGS OF OPERATION: TUMOR MASS IN PELVIS WITH METASTASES THROUGHOUT ABDOMINAL CAVITY	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) SUICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 19 , to MAR 25 1955 , that I last saw the deceased alive on MAR 24, 1955 , and that death occurred at 8:30 PM , from the causes and on the date stated above.			
SIGNATURE B Stanley Cohen, MD		ADDRESS 7306 Liberty Rd Balto 7, MD	
DATE SIGNED MAR 25 '55			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 3-29-55	
NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR 3-28-55		REGISTRAR'S SIGNATURE G. W. Hedrick	
24. FUNERAL DIRECTOR Ellsworth Armacost		ADDRESS Ellsworth Armacost 4600 Liberty Heights Ave.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

COLON COMB LIT V

4-10-67

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2336

CERTIFICATE OF DEATH

Reg. Dist. No.

02340

1. NAME OF DECEASED (Type or Print) JAMES S BLUMBERG		2. DATE OF DEATH 3-28-55	
3. PLACE OF DEATH: A. Baltimore City , Maryland Baltimore County		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY	
5. FULL NAME OF HOSPITAL OR INSTITUTION X 2701 Gwynmore Ave		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 3401-4	
D. STREET ADDRESS (If rural, give location) 3711 Liberty Heights Ave			
6. LENGTH OF STAY IN BALTIMORE 00 Yrs. Mos. Days		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Single	
8. SEX Male	9. COLOR OR RACE White	10. DATE OF BIRTH 12-18-1899	11. AGE (In years last birthday) 55
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Printer		13. KIND OF BUSINESS OR INDUSTRY	
14. FATHER'S NAME Isaac Blumberg		15. BIRTHPLACE (State or foreign country) Loch Haven Pa	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. MOTHER'S MAIDEN NAME Mary Fleishman	
18. SOCIAL SECURITY NO.		19. INFORMANT Lester H Blumberg	
20. ADDRESS			
18. 260X CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) (A) Acute Myocardial Infarction			
DUE TO			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Coronary Arteriosclerosis			
DUE TO (C) Diabetes Mellitus			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.			
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER* IN PART I OR PART II		19A. DATE OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Feb 15 1955 to March 28 1955 , that (I) (we) last saw the deceased alive on March 27 1955 , and that death occurred at 11 A m., from the causes and on the date stated above.			
23A. SIGNATURE Albert Rubinstein		23B. ADDRESS 5415 Park Heights Ave	
23C. DATE SIGNED March 29, 1955			
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 3-29-55	
24C. NAME OF CEMETERY OR CREMATORY Beth T Filoh		24D. LOCATION (City, town, or county) (State) Balto Md	
DATE RECEIVED BY LOCAL REGISTRAR March 29 1955		REGISTRAR'S SIGNATURE Jack Lewis	
25. FUNERAL DIRECTOR Jack Lewis		ADDRESS 7100 Eutaw Rd	

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

RECEIVED MAR 21 1955

BUREAU Y. S.

MAR 21 1955

RECEIVED

2337

CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write OR and give nearest town) <u>Pikesville</u>		LENGTH OF STAY (in this place) <u>21 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Pikesville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Nelson Rd</u>				STREET ADDRESS (If rural give location) <u>Nelson Rd</u>		1	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>William Edgar Bodensick</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>March 29 1955</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>		8. DATE OF BIRTH: <u>24 Jan 1894</u>	
				9. AGE last birthday <u>61</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Product</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Product</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>William Bodensick</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Bottenbacher</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY No. <u>214-24-0097</u>		17. INFORMANT & ADDRESS: <u>Mrs William Bodensick</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Chronic myelogenous leukemia</u>		<u>10 yrs</u>
ANTECEDENT CAUSE (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1 Dec.</u> , 19 <u>49</u> , to <u>29 Mar.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>29 Mar.</u> , 19 <u>55</u> , and that death occurred at <u>7:30 P.</u> M, from the causes and on the date stated above.					
SIGNATURE <u>Paul H. Rouse</u>		ADDRESS <u>Pikesville 8 md</u>		DATE SIGNED <u>29 Mar 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>APR 11 1955</u>		NAME OF CEMETERY OR CREMATORY <u>DPO & Ridge</u>	
LOCATION (City, town, or county) (State) <u>Pikesville MD</u>		24. FUNERAL DIRECTOR <u>Frank H. Mearl</u>		ADDRESS <u>Pikesville MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>March 30 1955</u>		REGISTRAR'S SIGNATURE <u>Karoly A. Mearl</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 5 1955

RECEIVED

2312

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02312

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Dundalk - 22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1827 East Avenue - 22</u>		STREET ADDRESS (If rural, give location) <u>7115 Holabird Avenue</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CHARLES</u> <u>KARL</u> <u>BORMAN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 2</u> <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>April 20, 1885</u>
9. AGE last birthday <u>69</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Poland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>pipe moulder</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Borman</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>1827 East Ave</u>	
17. INFORMANT AND ADDRESS <u>Mrs. John Michlich</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
592X Immediate cause (a) <u>arteriosclerotic Heart Disease</u>		<u>6 mo.</u>
Antecedent cause(s) (b) <u>Chronic nephritis</u>		<u>6 mo.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR?	

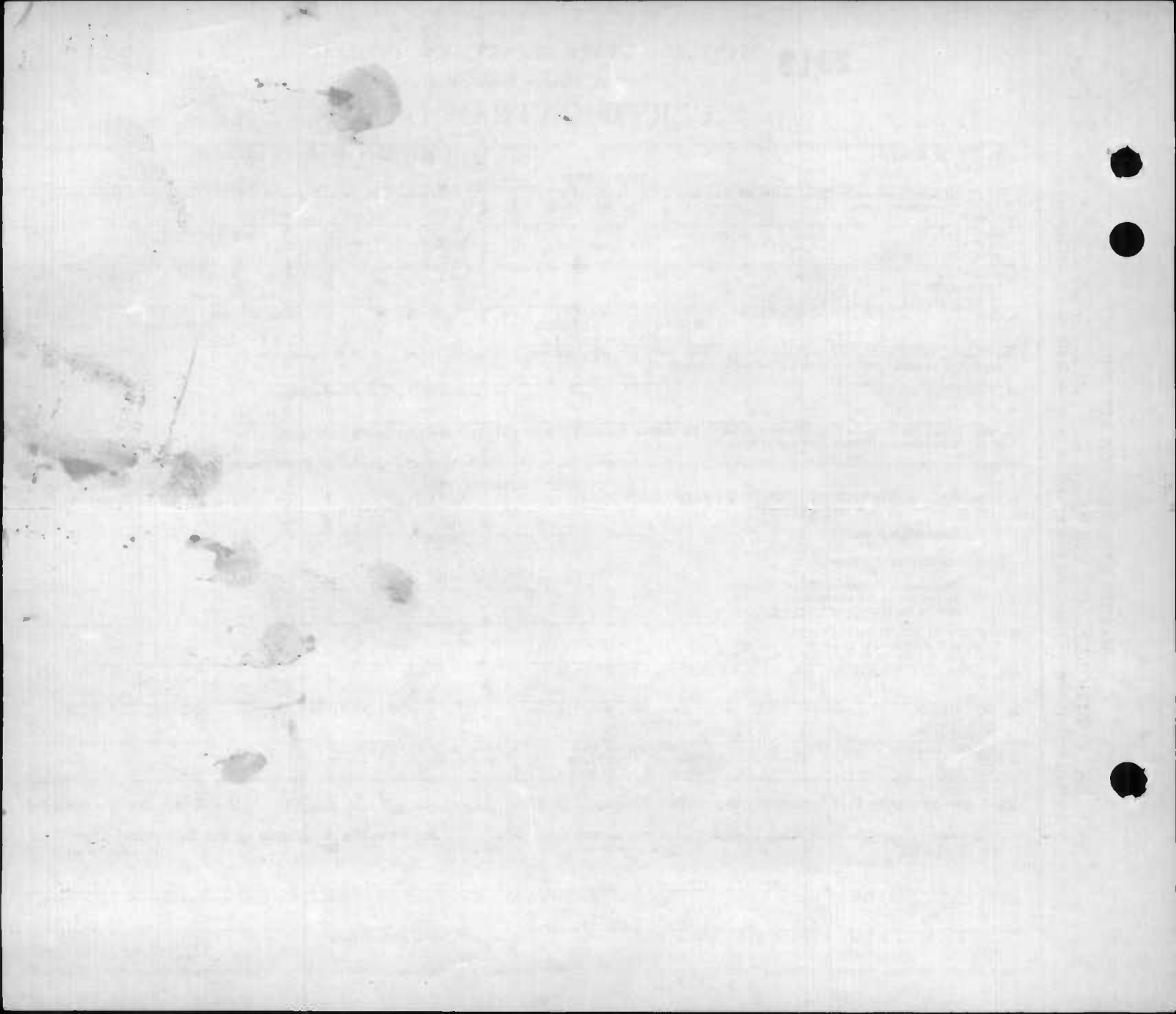
22. I hereby certify that I attended the deceased from Sept, 1954, to Mar, 1955, that I last saw the deceased alive on March 2, 1954, and that death occurred at 4:50 p.m., from the causes and on the date stated above.

SIGNATURE <u>Eugene F. Neely</u>		ADDRESS <u>M.D. 7001 Morrington Rd Dundalk, Md</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		DATE <u>March 6, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>1st United Evangelical</u>	
LOCATION (City, town, or county) <u>Baltimore, Maryland</u>		24. FUNERAL DIRECTOR <u>H. SANDER & SONS, INC.</u>		ADDRESS <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REG. <u>3-7-55</u>		REGISTRAR'S SIGNATURE <u>an Ped...</u>			

MARGIN RESERVED FOR BINDING

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 TOWN Catonsville</u>	LENGTH OF STAY <u>8 weeks</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson, Maryland</u> <u>55</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hosp</u>	STREET ADDRESS (If rural give location) <u>9 Linden Terrace</u> <u>1</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>May</u> <u>NMI</u> <u>BRANCAMP</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>March 27</u> <u>19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>Caud.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>9-17-1866</u>
9. AGE last birthday <u>88</u> yrs		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>Henry L. Bowen</u>	
14. MOTHER'S MAIDEN NAME: <u>Mary Parks Bowen</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT & ADDRESS: <u>Mrs. Henry L. Parlette</u> <u>Falls Road, Upperco, Md.</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE <u>334x</u> (A) <u>Respiratory failure</u>			<u>minutes</u>
ANTECEDENT CAUSE (S): (B) <u>Cerebral arteriosclerosis</u>			<u>years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized Arteriosclerotic vascular disease</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diarrhea of unknown cause; pyuria</u> <u>diarrhea</u> <u>and azotemia of undetermined cause</u> <u>4 hrs prior</u>			
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION: <u>to death</u>	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)	
20C. WHERE DID (City or town) (County) (State)		20D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
20E. INJURY OCCURRED While at work Not while at work		20F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan 31, 1955 to March 27 19 55 that I last saw the deceased alive on March 27 19 55, and that death occurred at 1 a.m. from the causes and on the date stated above.			
SIGNATURE <u>Lindsey D. Campbell</u>		ADDRESS <u>M. D. Spring Grove State Hosp. 1-27-55</u>	
DATE THEREOF <u>Mar 29, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>	
LOCATION (City, town, or county) (State) <u>Towson, Md.</u>		24. FUNERAL DIRECTOR ADDRESS <u>John Burns' Sons, Towson, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-27-55</u>		REGISTRAR'S SIGNATURE <u>E. W. DeLoach</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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2339

CERTIFICATE OF DEATH

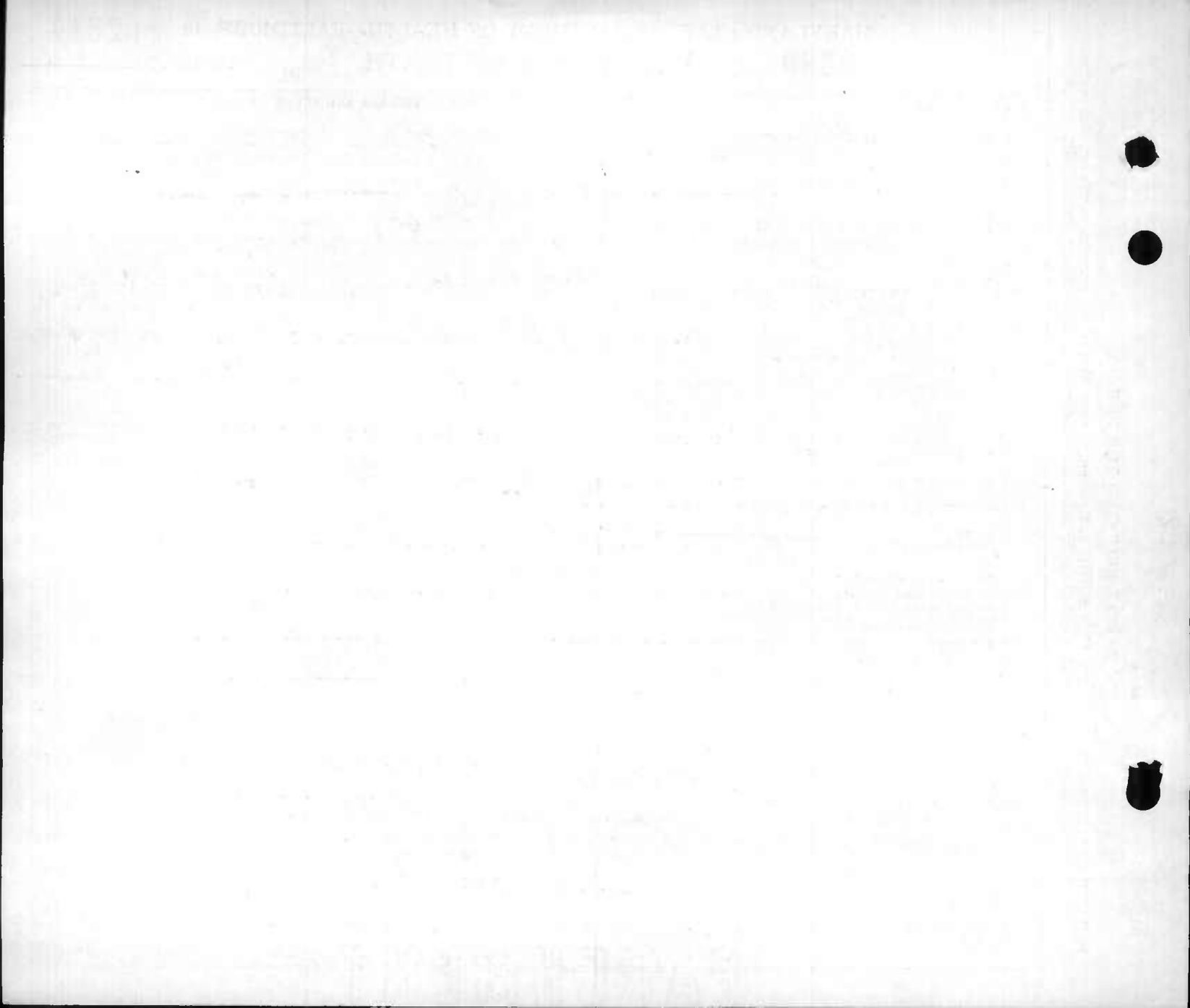
Reg. Dist. No. 45

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>54 Essex</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>54 Essex</u>	TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>609 Maryland Ave.</u>		STREET ADDRESS (If rural, give location) <u>609 Maryland Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>Lena</u> <u>Brashears</u>		DEATH: <u>March 7</u> - <u>19 55</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>June 8 - 1874</u>
9. AGE last birthday: <u>80</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Balto. Md.</u>	
11. FATHER'S NAME: <u>William Niemuller</u>		12. MOTHER'S MAIDEN NAME: <u>Margareta Schreiner</u>	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		14. SOCIAL SECURITY No.: <u>Edward Brashears 609 Maryland Ave.</u>	
15. INFORMANT & ADDRESS: <u>Edward Brashears 609 Maryland Ave.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
(a) Immediate cause <u>442X Arterio-sclerotic Hypertensive Cardio-vascular</u>		<u>6 years</u>
DUE TO (b) Antecedent cause(s) <u>Renal Disease</u>		
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION: <u>40</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>
HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>4/1/49</u> 19 <u>55</u> , to <u>March 7</u> 19 <u>55</u> , that I last saw the deceased alive on <u>March 7</u> 19 <u>55</u> , and that death occurred at <u>3:30 P.</u> m., from the causes and on the date stated above.		
SIGNATURE <u>J. White M.D.</u>		DATE SIGNED <u>3/8/55</u>
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
DATE REC'D BY LOCAL REG. <u>3-8-55</u>		24. FUNERAL DIRECTOR ADDRESS <u>Edmund J. Connelly Essex, Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2340

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wood Town</u>	STATE <u>Maryland</u> COUNTY <u>Balto.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Parkton</u>
OR TOWN <u>Wood Town</u>	LENGTH OF STAY (in this place) <u>4 mos.</u>	OR TOWN <u>Rural - Parkton</u>	STREET ADDRESS (If rural give location) <u>Prettyboy Dam Rd.</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2009 Thayers Terrace</u>			
3. NAME OF DECEASED: (First) <u>Daniel</u> (Middle) <u>R.</u> (Last) <u>Bruehl</u>		4. DATE OF DEATH: (Month) <u>March</u> (Day) <u>8</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Sept. 10, 1865</u>
9. AGE last birthday: <u>89</u> yrs.		10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Own Farm</u>	
11. BIRTHPLACE (State or foreign country): <u>Butler, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George Bruehl</u>		14. MOTHER'S MAIDEN NAME: <u>Rebecca Reyn.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u></u>	
17. INFORMANT & ADDRESS:			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>450.0</u>		<u>about</u>
Immediate cause (a) <u>Cardio vascular disease</u>		<u>2 yr.</u>
DUE TO		
Antecedent causes (s) (b) <u>Arterio sclerosis</u>		<u>?</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO		
(c)		

11. OTHER SIGNIFICANT CONDITIONS		
Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY ?		Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from <u>Feb. 19 55</u> to <u>Marc. 8, 19 55</u> , that I last saw the deceased alive on <u>Mar. 7, 19 55</u> and that death occurred at <u>7:45 AM</u> , from the causes and on the date stated above.	
SIGNATURE <u>John Stubbitt</u>	DATE SIGNED <u>3/8/55</u>
ADDRESS <u>2220 Garrison Blvd.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF
<u>Burial</u>	<u>March 11 1955</u>
NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Mt. Carmel Cemetery</u>	<u>Parkton, Balto. Co. Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE
<u>3-8-55</u>	<u>Aug. C. Bussell</u>
24. FUNERAL DIRECTOR	ADDRESS
<u>Jacob W. Winkler</u>	<u>New Freedom, Pa.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 10 1955

RECEIVED

Handwritten signature

2341

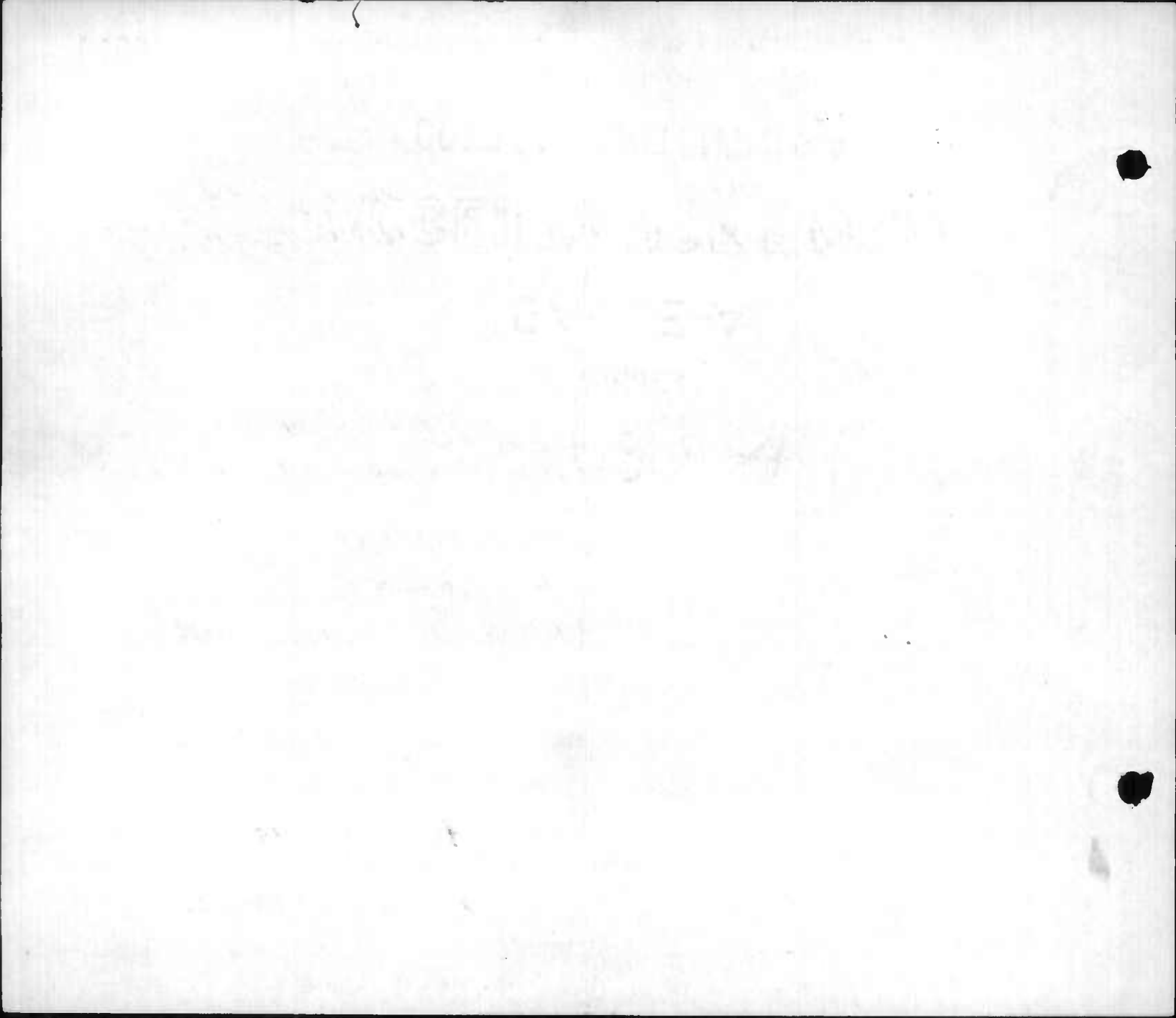
CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTO.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>RURAL - WOODLAWN</u>		<u>73 YRS.</u>		OR TOWN <u>RURAL - WOODLAWN</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1919 GWYNN OAK AVE.</u>				STREET ADDRESS (If rural give location) <u>1919 GWYNN OAK AVE.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>RHODA LOUISE BUCKHEIT</u>				<u>3 30 1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>3/25/82</u>	
				9. AGE last birthday: <u>73</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HOUSEWORK</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>HOUSEWORK</u>		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>WILLIAM COMPTON</u>				14. MOTHER'S MAIDEN NAME: <u>KATHERINE SCHANNESY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NUMBER: <u>220-03-3575</u>			
				17. INFORMANT & ADDRESS: <u>NONE NUMBER DAUGHTER - MILDRED FONTE</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CEREBRAL APOPLEXY</u>						<u>2 WEEKS.</u>	
ANTECEDENT CAUSE (B) <u>DIABETES MELLITUS</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>(260X) HYPERTENSIVE CARDIOVASCULAR DISEASE.</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/5</u> , 19 <u>55</u> , to <u>3/30</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/29</u> , 19 <u>55</u> , and that death occurred at <u>8:20 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Edwin G. Ruppert</u>		ADDRESS <u>8204 LIBERTY Rd., BALTO 7, Md.</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-2-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		LOCATION (City, town, or county) (State) <u>Woodlawn Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>50-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR ADDRESS <u>G. Howard Strong 3207 W. NORTH AVE.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2342

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND <input checked="" type="checkbox"/>		STATE <u>Md.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>		LENGTH OF STAY (in this place) <u>7 yrs-7m.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		<u>3401-4</u>	
TOWN <u>Cockeysville</u>				STREET ADDRESS (If rural give location) <u>2336 Edmondson Ave</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonic Home, Cockeysville</u>							
3. NAME OF DECEASED: (Type or Print) <u>Virginia</u> (First) <u>Buckley</u> (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>March 14</u> 19 <u>55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <u>Oct. 3rd, 1876</u>	
				9. AGE last birthday <u>78</u> yrs. <u>5</u> m.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore</u>	
13. FATHER'S NAME: <u>Rudolph Mateling</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Dorr</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>Laura M. Schroeder</u>	

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <u>Arterio-sclerotic Cardio-vascular disease</u>		<u>over 7 yrs</u>
ANTECEDENT CAUSE (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cerebral vascular accident</u>		<u>about 1 1/2 yrs</u>

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTO-PSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
-------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1947 to Mar 14 1955 that I last saw the deceased alive on Mar 13, 1955 and that death occurred at 7:30 A.M. from the causes and on the date stated above.

SIGNATURE <u>Walter J. Kuo</u> M. D.		ADDRESS <u>Cockeysville, Md</u>		DATE SIGNED <u>3/14/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)	
	<u>3/16/55</u>	<u>Goulden Pk</u>	<u>Baltimore Md</u>		
DATE REC'D BY LOCAL REGISTRAR <u>3/16/55</u>	REGISTRAR'S SIGNATURE <u>Laura M. Schroeder</u>	24. FUNERAL DIRECTOR <u>M. M. Cook</u>	ADDRESS <u>St Paul & Preston St</u>		

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 17 1955

RECEIVED

2343

CERTIFICATE OF DEATH

Reg. Dist. No.

02318 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Owings Mills		1 yr. 3¹/₂ mo.		TOWN Aberdeen		12-31-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rosewood State Training School				STREET ADDRESS (If rural give location) 156 Osborn Road			
3. NAME OF DECEASED: (First) Scott		(Middle) Braidwood		(Last) Bumgarner		4. DATE OF DEATH: (Month) 3 (Day) 28 (Year) 19 55	
5. SEX: male	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: 9/15/53		9. AGE last birthday: 18 mo.		
10a. USUAL OCCUPATION: Give kind of work done during most of working life, even if retired): --		10b. KIND OF BUSINESS OR INDUSTRY: --		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Russell C. Bumgarner				14. MOTHER'S MAIDEN NAME: Margaret Mears			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): --		16. SOCIAL SECURITY No.: --		17. INFORMANT & ADDRESS: Hospital Records			

18. MEDICAL CERTIFICATION						Interval Between Onset And Death	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
752X Immediate cause (a) Bilateral chronic interstitial pneumonitis						2 weeks	
Antecedent cause(s) (b) Most severe internal hypertensive hydrocephalus						birth	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE HOMICIDE		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/10/19 53 , to 3/28/19 55 , that I last saw the deceased alive on 3/28/19 55 , and that death occurred at 10:45 a.m. , from the causes and on the date stated above.							
SIGNATURE H. H. Butler M.D.				ADDRESS Owings Mills		DATE SIGNED 3/29/55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		3/30/55		Bakers cemetery		Aberdeen Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
March 30-55		Mary Elsie B		John G. Tarrington		Aberdeen, Md.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 31 1965

RECEIVED

2313

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Dundalk</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2980 Cornwall Road</u>		STREET ADDRESS (If rural give location) <u>3006 White Ave.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>JENNIE</u>	(Middle) <u>V.</u>	(Last) <u>BUSCH</u>	(Month) <u>March</u> (Day) <u>16</u> (Year) <u>19 55</u>
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 1, 1874</u>
9. AGE last birthday: <u>80</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>George Jones</u>		14. MOTHER'S MAIDEN NAME: <u>Don't know</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u>		16. SOCIAL SECURITY No.: <u>---</u>	
17. INFORMANT & ADDRESS: <u>Mrs. J. Stephenson 2980 Cornwall Road</u>			

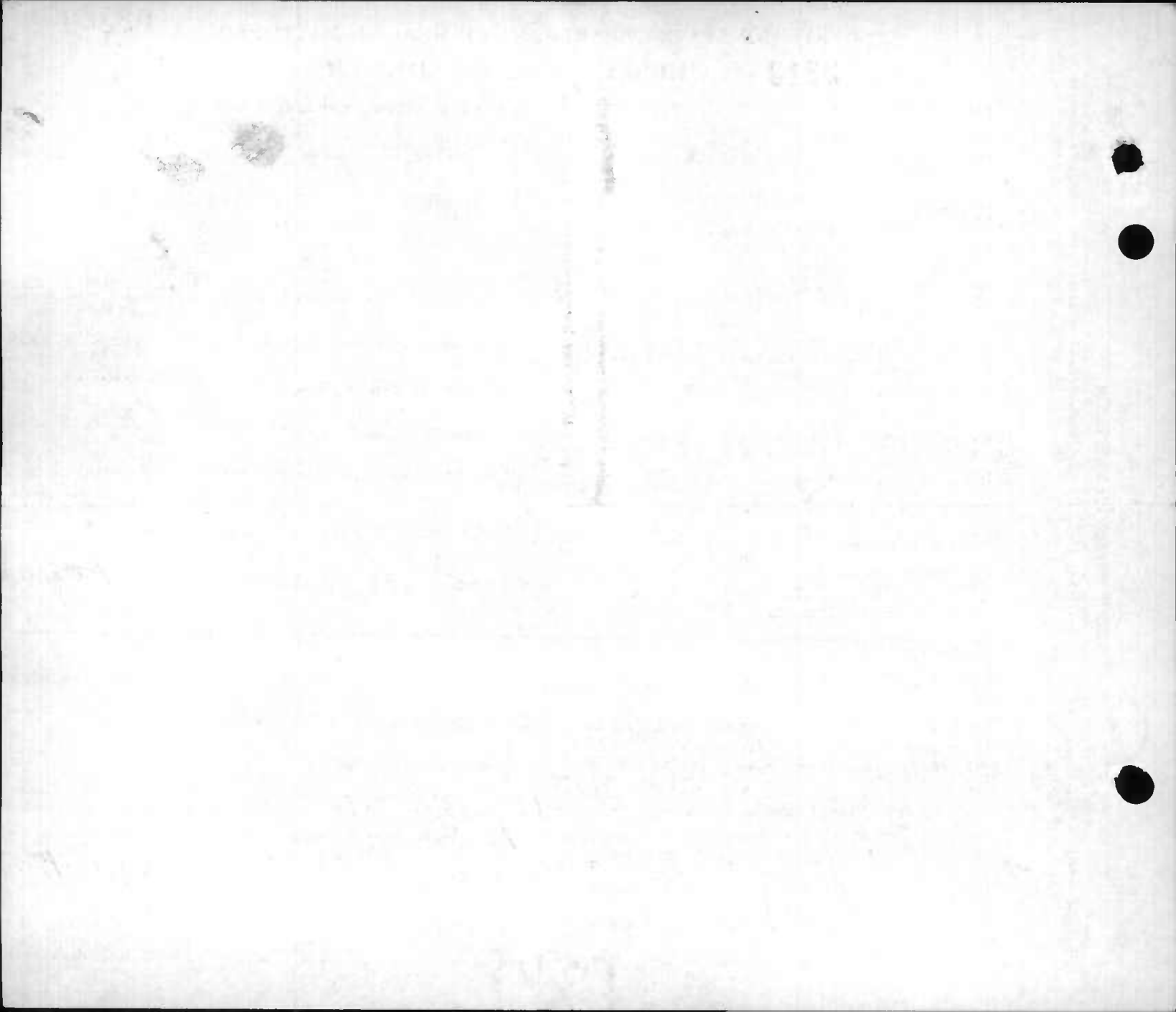
18. MEDICAL CERTIFICATION		Interval Between Onset and Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Arterio-Sclerotic heart disease</u>		<u>1 yr</u>
Antecedent causes (b) <u>Chronic nephritis</u>		<u>10 yrs</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death.		Yes <input type="checkbox"/> No <input type="checkbox"/>	
19a. DATE OF OPERATION: <u>3-12-1955</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			

22. I hereby certify that I attended the deceased from <u>3-12-1955</u> to <u>3-16-1955</u> , that I last saw the deceased alive on <u>3-15-1955</u> and that death occurred at <u>12 Noon.</u> from the causes and on the date stated above.			
SIGNATURE <u>Eugene F. Neveu M.D.</u>		DATE SIGNED <u>March 17, 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-18-55</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
REGISTRAR'S SIGNATURE <u>R. W. Hedding</u>		24. FUNERAL DIRECTOR ADDRESS <u>Ullrich Funeral Home 2112 Dundalk Ave. 22</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2344

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02321

CERTIFICATE OF DEATH

Reg. Dist. No. 38

Items 8, 9, Film GL80 4-25-55 et

1. PLACE OF DEATH COUNTY <u>Hyde Park Md</u> <u>Balto. Co.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hyde Park</u> TOWN <u>Hyde Park</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>—</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u> TOWN <u>Balto</u> STREET ADDRESS (If rural, give location) <u>Hyde Park Md</u>	
3. NAME OF DECEASED (First) <u>James</u> (Middle) <u>Lealdwell</u> (Last) <u>—</u>		4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>17</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept 24, 1914</u> 41/40 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Route Manager Archers Laundry</u>		11. BIRTHPLACE (State or foreign country) <u>Md</u>	
13. FATHER'S NAME <u>Wm Lealdwell</u>		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Lillian Lealdwell, Hyde Park Md</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

148X Immediate cause

(a) Physician

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

(b) Carcinoma of pharynx with metastases(c) —

INTERVAL BETWEEN ONSET AND DEATH

1 hr.7 mos.II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2/10, 1955, to 3/17, 1955, that I last saw the deceased alive on 2/16, 1955, and that death occurred at 4 P. m., from the causes and on the date stated above.

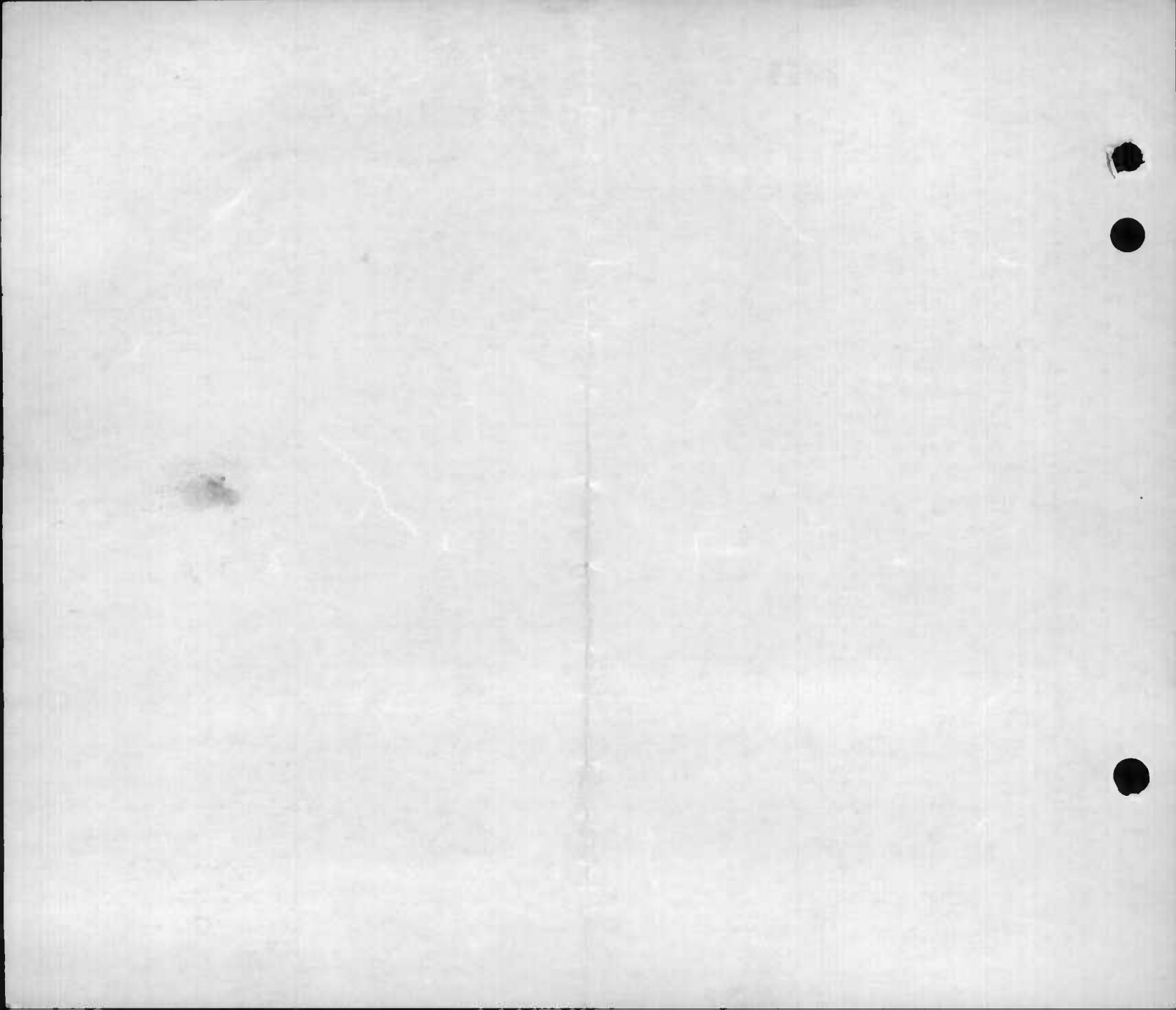
SIGNATURE J. Lealdwell, Md

(Degree or title)

ADDRESS 434 Eastern Ave, East, Md.DATE SIGNED 3/17/5523. BURIAL, CREMATION
REMOVAL (Specify)DATE THEREOF Mar 21, 1955NAME OF CEMETERY OR CREMATORY Oak LawnLOCATION (City, town, or county) Eastern Ave Rd

(State)

DATE REC'D BY LOCAL
REG. 3-18-55REGISTRAR'S SIGNATURE —24. FUNERAL DIRECTOR Leo E. BookADDRESS 1704 3rd Patterson Park Ave



CERTIFICATE OF DEATH

Reg. Dist. No.

44

Interval Between Onset And Death

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 17 1955

BUREAU V. S.

2346

MARYLAND STATE DEPARTMENT OF HEALTH

02323

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH: COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MARYLAND</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>PARKVILLE</u>	
TOWN <u>PARKVILLE</u>		TOWN <u>PARKVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3117 E Joppa Rd</u>		STREET ADDRESS (If rural, give location) <u>3117 E Joppa Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Katherine E</u> (First) <u>E</u> (Middle) <u>CARNEY</u> (Last)		4. DATE OF DEATH <u>MARCH 13</u> (Month) <u>13</u> (Day) <u>1955</u> (Year)	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED , DIVORCED , (Specify)	8. DATE OF BIRTH <u>8-2-1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CAN CO.</u>	9. AGE last birthday <u>62</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>THOMAS CARNEY</u>		14. MOTHER'S MAIDEN NAME <u>MARY McDERMOTT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>212-01-6795</u>	
17. INFORMANT <u>Cecelia CARNEY 3117 E Joppa Rd</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422.2 Immediate cause (a) <u>Adam's Stokes Syndrome</u>		
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Myocarditis and</u>		
(c) <u>Congestive Failure</u>		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
---	--

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 1, 1953 to March 13, 1955, that I last saw the deceased alive on Mar 1, 1955, and that death occurred at 6:30 A.M. from the causes and on the date stated above.

SIGNATURE Frank V. Kasik, Jr. M.D. (Degree or title) ADDRESS 9005 Harford Rd. DATE SIGNED 3/15/55

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>3/16/55</u>	NAME OF CEMETERY OR CREMATORY <u>PARKWOOD</u>	LOCATION (City, town, or county) <u>BALTO.</u> (State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>Mar. 15, 1955</u>	REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>	24. FUNERAL DIRECTOR <u>CHAS F EVANS & Son</u>	ADDRESS <u>8802 HARTFORD Rd</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 16 1955

RECEIVED

2347

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Balto.	MARYLAND	STATE Md.	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 52 Catonsville	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 51 Halethorpe	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 House in the Pines 16 Fusting Ave.		STREET ADDRESS (If rural give location) 1824 Park Ave.	
3. NAME OF DECEASED: (First) (Middle) (Last) LOTTIE PACE CAROTHERS		4. DATE (Month) (Day) (Year) OF DEATH: Mar. 8, 19 55	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): married	8. DATE OF BIRTH: July 24, 1877
9. AGE last birthday: 77 yrs.		10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): --		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Virginia		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: John R. Pace		14. MOTHER'S MAIDEN NAME: Sallie Hagerman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: Halethorpe, Md. Mr. Joseph H. Carothers - 1824 Park Ave.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) 443X Hypertensive A.S.C.V.D.			
ANTECEDENT CAUSE (B) terminal congestive failure			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/4, 1954 to 3/8, 1955 that I last saw the deceased alive on 3/7, 1955 , and that death occurred at 439 M, from the causes and on the date stated above.			
SIGNATURE [Signature]		DATE SIGNED 3/9/55	
ADDRESS Halethorpe Md		M. D.	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Removal		3/10/55	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Greenhill Cem.		Danville, Va.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
3-9-55		V.E. Harry	
24. FUNERAL DIRECTOR		ADDRESS	
Wm. J. Schenker & Sons - Balto		17	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 11 1955

RECEIVED

2348

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Betta</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Pikesville</u>		<u>3 2 yrs</u>		TOWN <u>Pikesville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Smith Ave</u>				STREET ADDRESS (If rural give location) <u>Smith Ave</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) <u>CAROLINE</u> (Middle) <u>MAY</u> (Last) <u>Carter</u>				<u>March 31 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>		8. DATE OF BIRTH: <u>14 May 1890</u>	
9. AGE last birthday <u>64</u> yrs.		IF UNDER 1 YEAR Months		IF UNDER 24 HRS. Days		Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William Gaigler</u>				14. MOTHER'S MARDEN NAME: <u>Mary Bothoff</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY No. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mr Wilson H Carter, seven mi Lane Pikesville</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral vascular accident</u>						<u>4 days</u>	
ANTECEDENT CAUSE (B) <u>Hypertension</u>						<u>3 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>18 Oct</u> , 19 <u>54</u> , to <u>31 Mar</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>30 Mar</u> , 19 <u>55</u> , and that death occurred at <u>2:30</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>Paul & Rayse</u>		ADDRESS <u>Pikesville 8th</u>		DATE SIGNED <u>31 Mar 55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4/2/55</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-4-55</u>		REGISTRAR'S SIGNATURE <u>PO</u>		24. FUNERAL DIRECTOR <u>Wm. J. Pickens & Sons - Balt</u>		ADDRESS <u>md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

EXPERIMENT

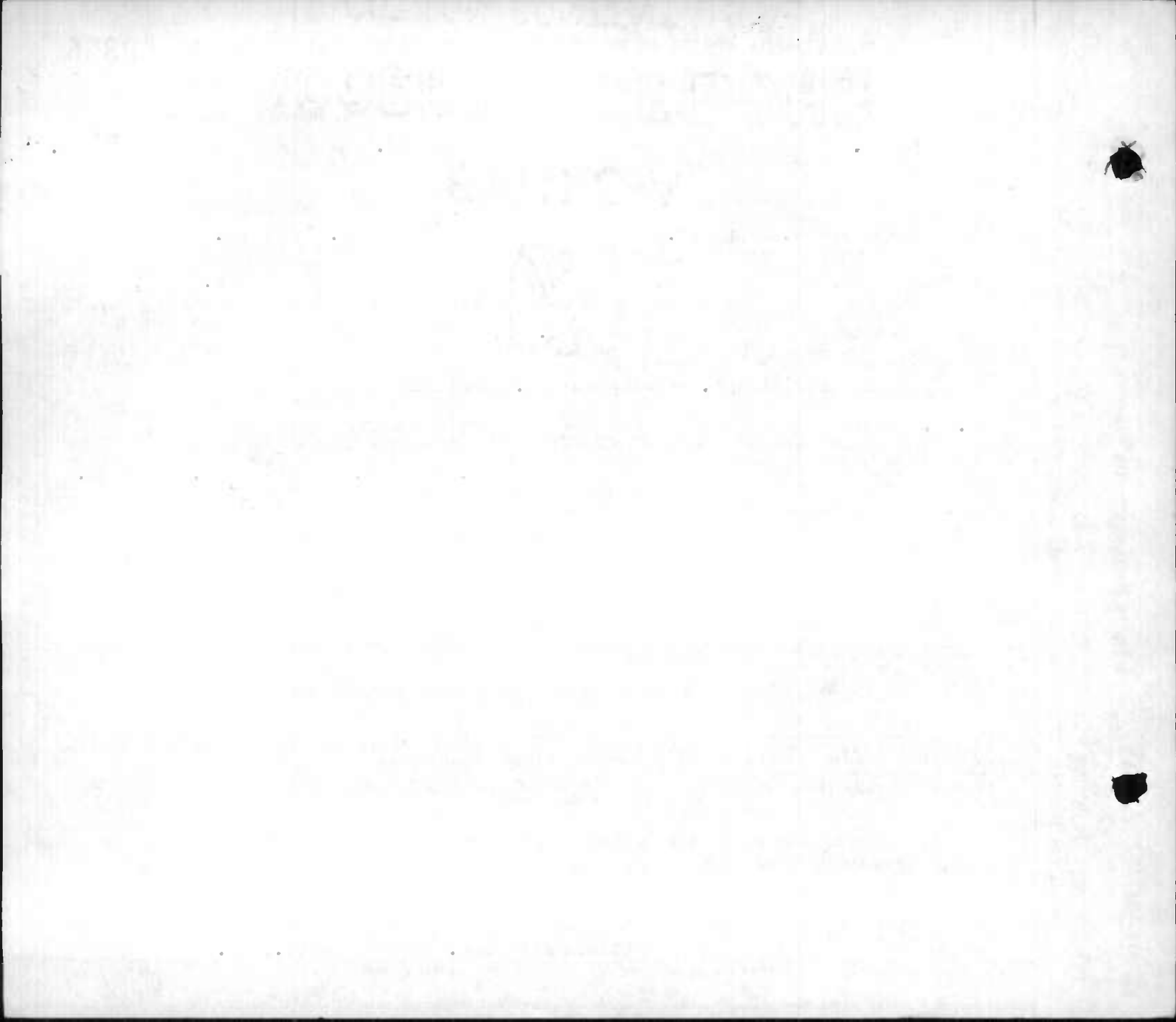
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02326

2349 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Towson</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>505 W. Joppa Rd.</u>	STREET ADDRESS (If rural give location) <u>505 W. Joppa Rd.</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>JUDSON E. CLARKE</u>		DATE OF DEATH: <u>Mar. 21, 1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Dec. 24, 1899</u>
9. AGE last birthday <u>55</u> yrs.		10. MONTHS <u>55</u>	11. DAYS <u>21</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Commercial Agt. - Telephone Co.</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Wm. J. Clarke</u>		14. MOTHER'S MAIDEN NAME: <u>Mary MacKenzie</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Mrs. Leona E. Clarke-505 W. Joppa Rd.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>HEMORRHAGE, Cerebral arterial</u>		<u>5. minutes</u>	
ANTECEDENT CAUSE (B) <u>HYPERTENSION, Arterial</u>		<u>4 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 14, 1955</u> , to <u>March 21, 1955</u> , that I last saw the deceased alive on <u>Jan 14, 1955</u> , and that death occurred at <u>2:15 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>A.S. Chasnow</u>		ADDRESS <u>6710 Yorky</u> DATE SIGNED <u>March 22, 55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/23/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/24/55</u>		REGISTRAR'S SIGNATURE <u>A.W. Hedrick</u>	
FUNERAL DIRECTOR <u>Wm. J. Pickner & Sons</u>		ADDRESS <u>Balto., Md.</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

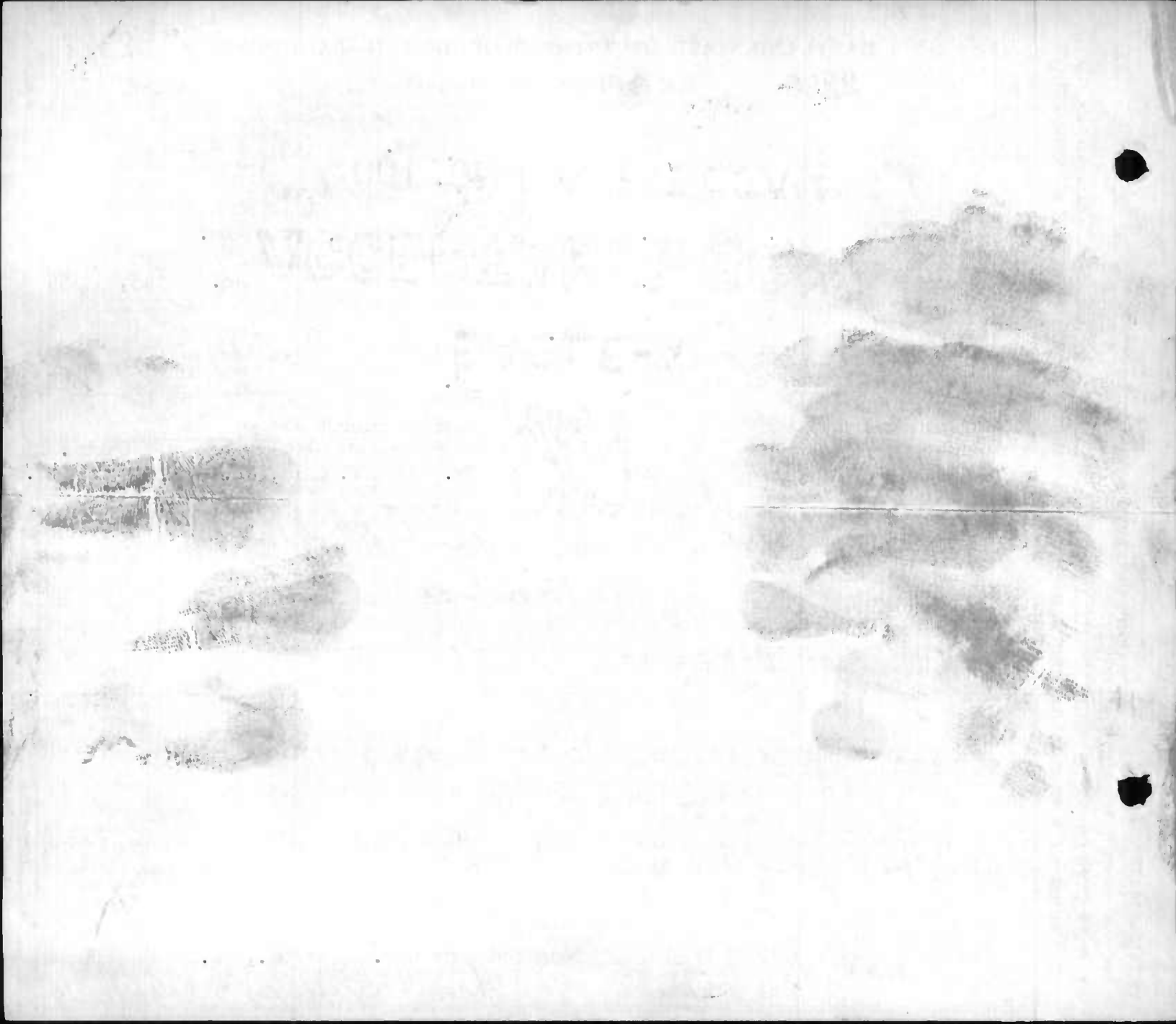
02327

2350

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
X TOWN <u>Rogers Forge</u>				TOWN <u>Rogers Forge</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		211 S. Tyrone Rd.		STREET ADDRESS		(If rural give location) 211 S. Tyrone Rd.	
3. NAME OF DECEASED: (First) <u>NELLYE</u> (Middle) <u>T.</u> (Last) <u>COLE</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar.</u> <u>15</u> , 19 <u>55</u>			
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Apr. 15, 1867</u>	9. AGE last birthday <u>87</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Nichols Tillman</u>				14. MOTHER'S MAIDEN NAME: <u>Matilda Storck</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Balto. 10 Mr. Edwin T. Cole, Jr. - Tidgemede Apts.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Acute Cardiac Failure</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>Arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 1, 1953</u> , to <u>March 16, 1955</u> , that I last saw the deceased alive on <u>3/16</u> 19 <u>55</u> , and that death occurred at <u>7:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Lawrence C. Koch M.D.</u>		ADDRESS <u>6805 York Rd - Baltimore 12</u>		DATE SIGNED <u>3/17/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/19/55</u>		NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer Cem.</u>		LOCATION (City, <u>Balto., Md.</u> or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>3-18-55</u>		REGISTRAR'S SIGNATURE <u>Dr. H. H. H. H.</u>		FUNERAL DIRECTOR <u>Chas. J. H. H. H.</u>		ADDRESS <u>1400 N. E. St. Baltimore 12</u>	



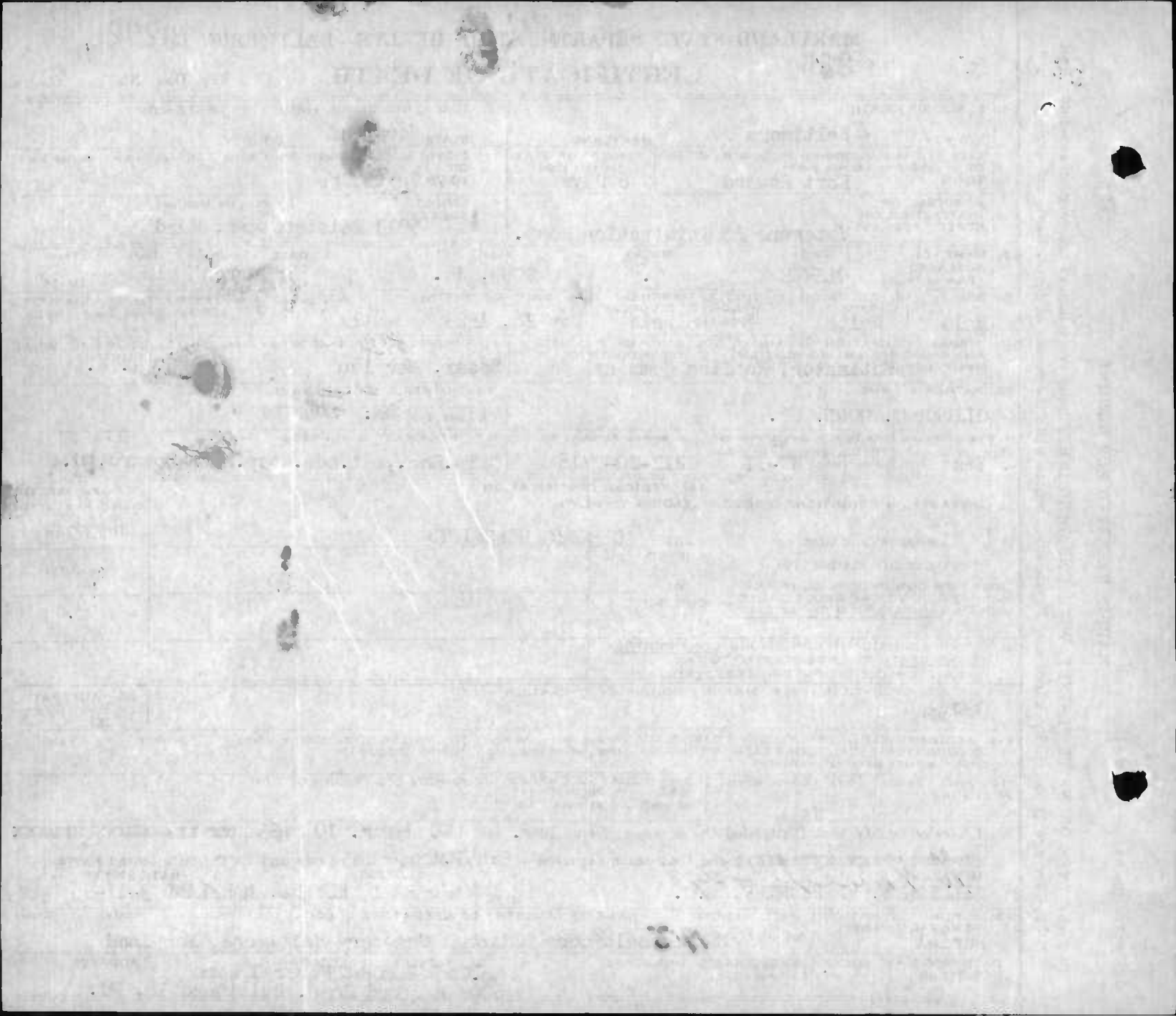
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 102328 2351

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Fort Howard		LENGTH OF STAY (in this place) 6 Days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hosp.				STREET ADDRESS (If rural give location) 5013 Reisterstown, Road			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) OLIVER		(Middle) C.		(Last) CONN, JR.		March 10 19 55	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH: May 26, 1925	9. AGE last birthday 29 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Estimator, Roofing Company			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Essex, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME: OLIVER C. CONN, SR.				14. MOTHER'S MAIDEN NAME: LILLIAN MN. SCHMIDT			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW-II			16. SOCIAL SECURITY NO. 212-20-7718		17. INFORMANT & ADDRESS: Clin. Rec., Vet. Adm. Hosp. Fort Howard, Md.		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
592X IMMEDIATE CAUSE (A) CHRONIC NEPHRITIS							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C)							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that Dattended the deceased from Mar. 4, 1955 , to Mar. 10, 1955 , and that death occurred at 5:45 P.M. , from the causes and on the date stated above. SIGNED WILLIAM B. VANDEGRIFT, M.D. DATE SIGNED M. D. VAH, FORT HOWARD, MARYLAND 3-11-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF MAR. 14, 1955		NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR 12 1955		REGISTRAR'S SIGNATURE <i>Wm. Cook-Blight</i>		24. FUNERAL DIRECTOR Wm. Cook-Blight Funeral Home		ADDRESS 6009 Harford Road, Baltimore 14, Md.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02329
2352 CERTIFICATE OF DEATH

Reg. Dist. No. 48

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Wicomico</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>51 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mardela Springs</u> <u>22X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>Route 1, Box 72</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ELISHA M. COOK</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>March 10 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>2/13/21</u>	9. AGE last birthday <u>34</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Culler</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Oyster House</u>		11. BIRTHPLACE (State or foreign country): <u>Mardela Springs, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>John Cook</u>				14. MOTHER'S MAIDEN NAME: <u>Daisy Waller</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW II</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>260X</u>							
(A) <u>SOFTENING AND DISCOLORATION OF LENTICULAR NUCLEI OF BRAIN</u>						UNKNOWN	
ANTECEDENT CAUSE (S): <u>Due To DIABETES MELLITUS</u>						UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) <u>Due To</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>3-9-55</u>		19B. MAJOR FINDINGS OF OPERATION <u>Exploratory Laporatomy for paralytic ileus- duration 1 hr.</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan. 18, 1955</u> to <u>Mar. 10, 1955</u> , and that death occurred at <u>9:20 M.</u> from the causes and on the date stated above.							
SIGNATURE <u>W. B. Van Degriest, M.D.</u>		ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>3-11-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/12/1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Pleasant Cemetery</u>		LOCATION (City, town, or county) (State) <u>Mardela Springs, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>W. B. Van Degriest</u>		24. FUNERAL DIRECTOR <u>Arlington S. Phillips</u>		ADDRESS <u>1808 N. Monroe St., Baltimore 17, Md.</u>	

MARGIN RESERVED FOR BINDING

V.S. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Released at Baltimore, Md.

5355

RECEIVED BY THE OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

1917

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

1917

OFFICE OF THE SECRETARY OF THE ARMY

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WASHINGTON, D. C.

1917

OFFICE OF THE SECRETARY OF THE ARMY

WASHINGTON, D. C.

2353

CERTIFICATE OF DEATH

Reg. Dist. No. *XX*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Fort Howard		LENGTH OF STAY (in this place) 4 Days		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 Veterans Administration Hospital		STREET ADDRESS (If rural give location) 2322 Cambridge Street					
3. NAME OF DECEASED: (First) JOSEPH		(Middle) (NMI)		(Last) COOK		4. DATE (Month) (Day) (Year) OF DEATH: March 16, 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Divorced	8. DATE OF BIRTH: March 26, 1888		9. AGE last birthday: 66 yrs.	IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10B. KIND OF BUSINESS OR INDUSTRY: Manning Meat Pack.		11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: Joseph Cook				14. MOTHER'S MAIDEN NAME: Mary MN: Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW-I				16. SOCIAL SECURITY NO. 220-09-0462		17. INFORMANT & ADDRESS: Clin. Rec. Vet. Adm. Hospital, Ft. Howard, Md.	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE (A) MYOCARDIAL INFARCTION						24 HRS. Plus	
ANTECEDENT CAUSE (B) DUE TO ARTERIOSCLEROTIC CORONARY THROMBOSIS						24 HRS. Plus	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: VA M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Mar. 12, 1955 , to Mar. 16, 1955 , that I last saw the deceased 7:20AM , and that death occurred at 7:20AM , from the causes and on the date stated above.							
SIGNATURE <i>Irving Freeman</i>				ADDRESS		DATE SIGNED	
IRVING FREEMAN, M.D. Acting Chief, Medical Service VAH, Fort Howard, Md. 3-16-55							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF MAR. 21, 1955		NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR 3-17-55		REGISTRAR'S SIGNATURE <i>Wm. Cook</i>		24. FUNERAL DIRECTOR Wm. Cook-Blight Inc.		ADDRESS 6009 Harford Road, Baltimore 14, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2354

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02331

CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikeville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Pikeville 8, MD</u>	
TOWN <u>Pikeville</u> LENGTH OF STAY (in this place) <u>2 months</u>		TOWN <u>Pikeville 8, MD</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>815 Templehill Road</u>		STREET ADDRESS (If rural, give location) <u>815 Templehill Road</u>	
3. NAME OF DECEASED (First) <u>Edna</u> (Middle) <u>Marie</u> (Last) <u>Cooper</u>		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>4</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>Sept 25, 1896</u>
9. AGE last birthday <u>58</u> yrs.		10. If under 1 year: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>R. W.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (State or foreign country) <u>Parkton, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Stippler</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Frances Spicer</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Mrs. Edith Benney, daughter</u>			

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

156.1
Immediate cause

(a) Carcinoma, liver

Antecedent cause(s)
Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last

(b) —

(c) —

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

March 1954 Carcinoma liver to metastasis

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 18 Jan, 1955, to 4 March, 1955, that I last saw the deceased

alive on 4 March, 1955, and that death occurred at 4 P. m., from the causes and on the date stated above.

SIGNATURE Charles H. Williams (Degree or title) ADDRESS 1632 Reis. Rd. Pikeville DATE SIGNED 4 March 55

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>3-7-55</u>	NAME OF CEMETERY OR CREMATORY <u>PINE GROVE</u>	LOCATION (City, town, or county) <u>RAYVILLE MD</u>	(State)
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <u>Dorothy Newell</u>	24. FUNERAL DIRECTOR <u>Frank H. Newell</u>	ADDRESS <u>Pikeville, MD</u>	

EJ.

RECEIVED

MAR 8 1955

BUREAU V. S.

2355

MARYLAND STATE DEPARTMENT OF HEALTH

02332

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY BALTO	
55 CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWSON		CITY (If outside corporate limits, write RURAL and give nearest town) RURAL TOWSON 55	
100 HOSPITAL OR INSTITUTION OR STREET ADDRESS 1666 YAKONA AVE.		STREET ADDRESS (If rural, give location) 1666 YAKONA AVE 1	
3. NAME OF DECEASED (Type or Print) FANNIE M. CORSI		4. DATE OF DEATH MARCH 31 1955	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH MARCH 28 1910
9. AGE last birthday 45 yrs.		10. If under 1 year 11. If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) OPERATOR		10b. KIND OF BUSINESS OR INDUSTRY BENDIX CORP.	
11. BIRTHPLACE (State or foreign country) ITALY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME VINCENT MODO		14. MOTHER'S MAIDEN NAME RASALIE GIORDANO	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY No. 217-01-6560	
17. INFORMANT AND ADDRESS FREDERICK CORSI 1666 YAKONA AVE			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
175X Immediate cause (a) Respiratory failure					
Antecedent cause(s) (b) Carcinoma of the breast - generalized metastases					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Feb 25 1955 , to March 31 1955 , that I last saw the deceased alive on March 25 1955 , and that death occurred at 2:25 P.M. , from the causes and on the date stated above.					
SIGNATURE Charles J. Black M.D.		ADDRESS 914 N. Charles St.		DATE SIGNED 4/1/55	
23. BURIAL CREMATION REMOVAL (Specify) BURIAL		DATE APR 4 1955		NAME OF CEMETERY OR CREMATORY HOLY REDEEMER CEM	
LOCATION (City, town, or county) MD.		24. FUNERAL DIRECTOR Duffel Bros		ADDRESS 1800 E LOMBARD ST.	
DATE REC'D BY LOCAL REG. April 2 1955		REGISTRAR'S SIGNATURE R.W.			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DR BLAZER 914 N CHARLES ST.

2356

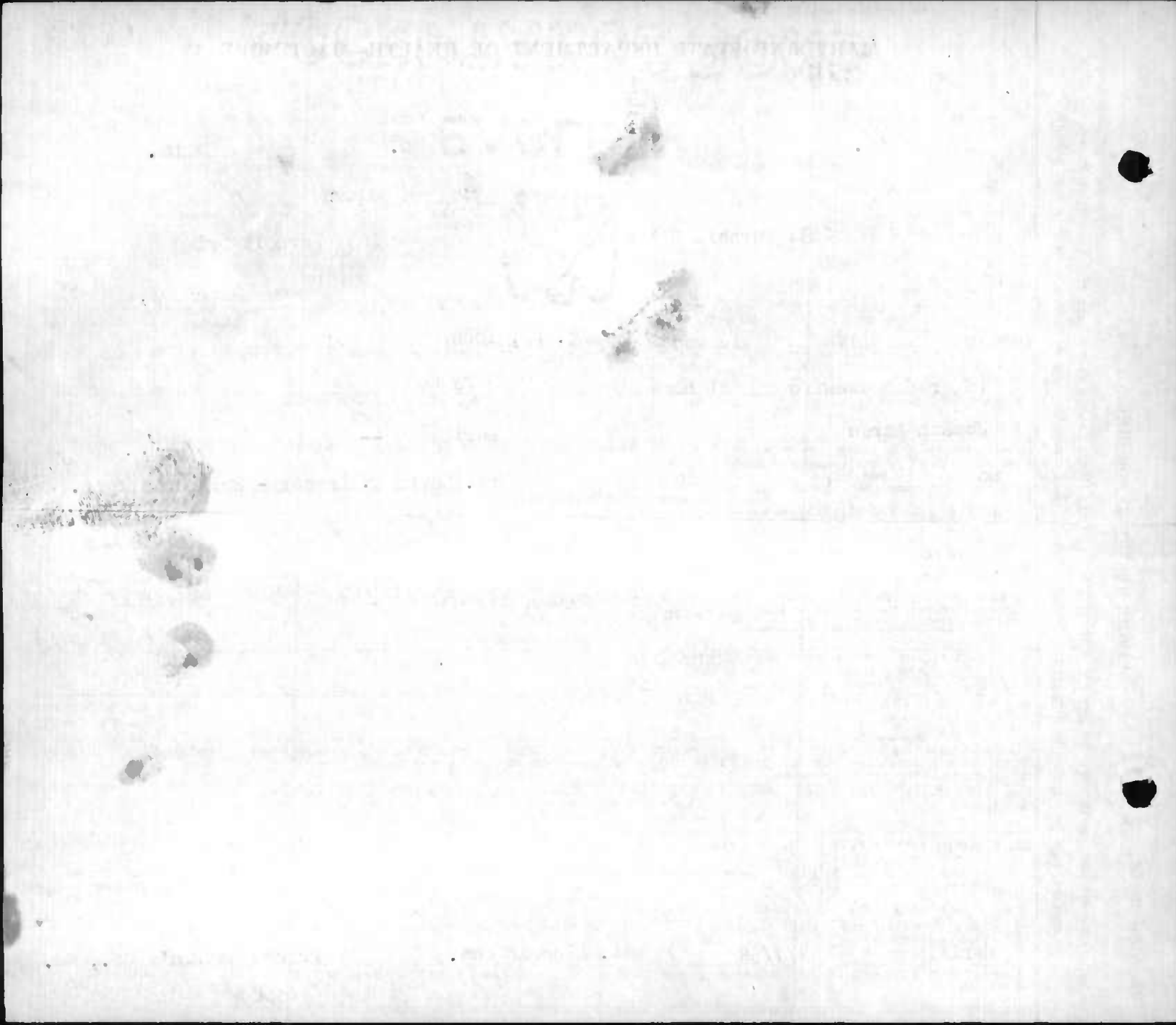
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Balto.	MARYLAND	STATE Md.	COUNTY Balto.
CITY (If outside corporate limits, write RURAL and give nearest town) Woodlawn	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodlawn	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 2631 Purnell Drive		STREET ADDRESS (If rural give location) 2631 Purnell Drive	
3. NAME OF DECEASED: (First) (Middle) (Last) BESSIE COVEY		4. DATE (Month) (Day) (Year) OF DEATH: March 3, 1955	
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed	8. DATE OF BIRTH: Aug. 21, 1888
9. AGE last birthday 66 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired Housewife		10B. KIND OF BUSINESS OR INDUSTRY: at home	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Joseph Aaron		14. MOTHER'S MAIDEN NAME: Bertha	
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY? (Yes, no, or unk.) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT & ADDRESS: Mrs. David C. Iesher - 2631 Purnell Dr.			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE 260X		2 hours	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) Coronary Thrombosis			
(B) arteriosclerotic Cardio-Vascular Dis.		1 1/2 yrs	
(C) Diabetes		10 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: no operation		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Oct 8, 1953 to March 3, 1955 , that I last saw the deceased alive on March 3, 1955 , and that death occurred at 10:20 PM , from the causes and on the date stated above.			
SIGNATURE Joshua H. Amason		DATE SIGNED 3-5-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/7/55	
NAME OF CEMETERY OR CREMATORY Ft. Lincoln Cem.		LOCATION (City, town, or county) (State) Prince George's Co., Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE Wm. J. Dickner	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2357

02334

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTO.</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>BALTO.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>CATONSVILLE</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>933 W. Lexington St.</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <u>THEODORE</u> (Middle) <u>CZAK</u> (Last)		3 - 13 - 19 55	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>SINGLE</u>	8. DATE OF BIRTH: <u>unknown</u>
9. AGE last birthday: <u>approx 63</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>unknown</u>	
11. BIRTHPLACE (State or foreign country): <u>AUSTRIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>AUSTRIA</u>	
13. FATHER'S NAME: <u>JULIUS CZAK</u>		14. MOTHER'S MAIDEN NAME: <u>MARIA PARAGE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u></u>	
17. INFORMANT & ADDRESS:			

18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>420.1</u> <u>Acute cardiac failure due to</u> DUE TO			
Antecedent cause(s) (b) <u>coronary occlusion</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>Herb M. Kieffer</u> 1010 Lechman		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>Mar 13 1955</u>	
DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>	DATE THEREOF: <u>3/16/55</u>	NAME OF CEMETERY OR CREMATORY: <u>Mount Vernon</u>	LOCATION (City, town, or county) (State): <u>Balto, Md.</u>
DATE REC'D BY LOCAL REG. <u>3-16-55</u>	REGISTRAR'S SIGNATURE: <u>T.E. Harry</u>	24. FUNERAL DIRECTOR: <u>Mrs. F. H. Hemmley</u> ADDRESS: <u>579 W. Biddle St.</u>	

RECEIVED

MAR 18 1955

BUREAU V. S.

2358

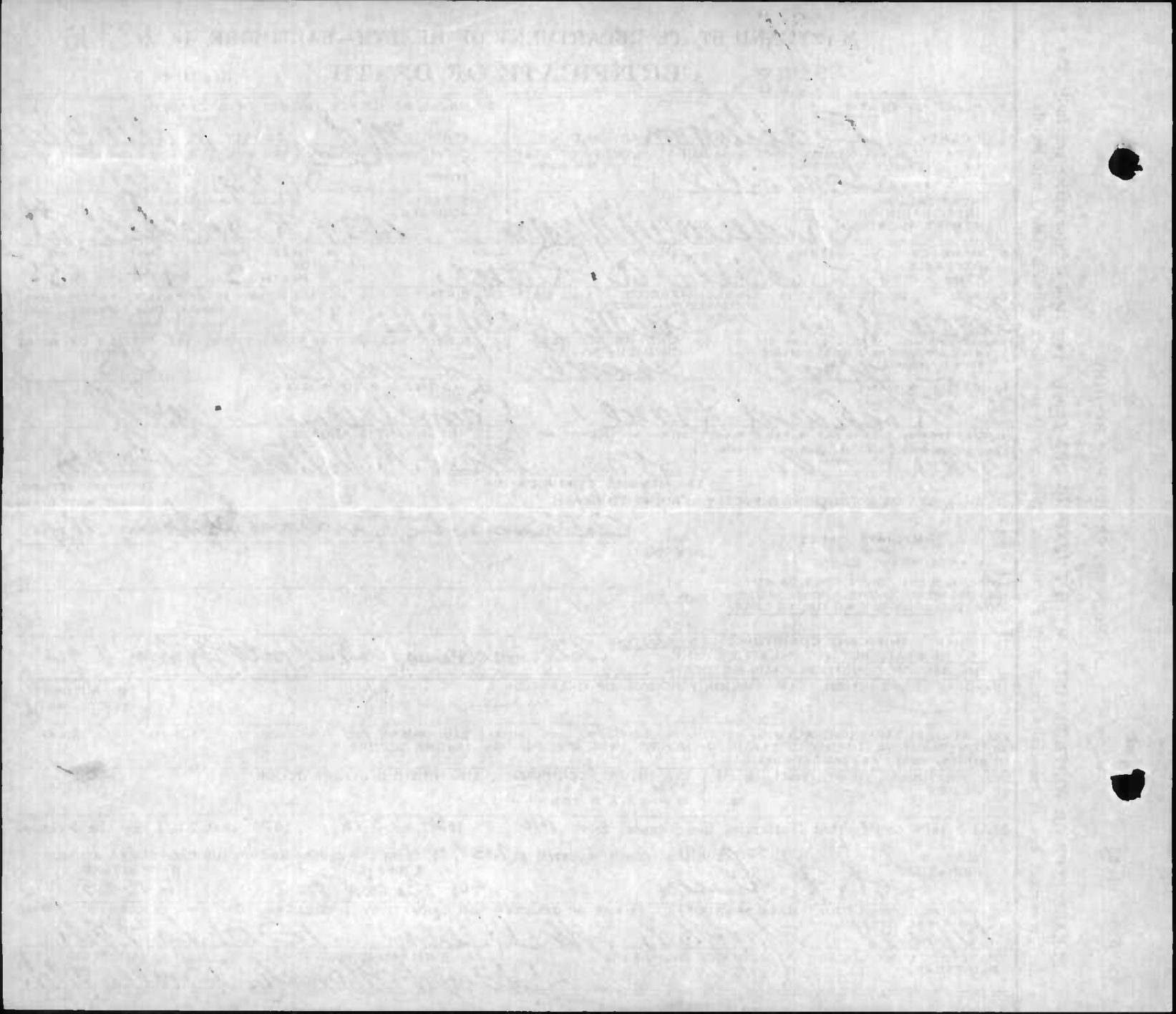
CERTIFICATE OF DEATH

Reg. Dist. No. 30

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Calonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgeway Manor</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> STREET ADDRESS <u>1534 Roundhill Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Russilla A. Dare</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>3 14 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>July 29/68 89</u>	9. AGE last birthday: <u>89</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>Richard Dare</u>				14. MOTHER'S MAIDEN NAME: <u>Caroline Shemwell</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVAL SERVICE? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>No</u>				16. SOCIAL SECURITY NO.: <u>No</u>		17. INFORMANT & ADDRESS: <u>Mrs E. F. Watters 1413 Balto</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Arteriosclerotic Cardiovascular Disease</u>						<u>11 yrs.</u>	
ANTECEDENT CAUSE (B) <u>DUE TO</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>DUE TO</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerosis, Cerebral, with Bysses</u>						<u>2 yrs.</u>	
19A. DATE OF OPERATION: <u>—</u>				19B. MAJOR FINDINGS OF OPERATION: <u>—</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, etc.) OF INJURY: <u>—</u>		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>—</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>1-14</u> , 19 <u>54</u> , to <u>3-15</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-14</u> , 19 <u>55</u> , and that death occurred at <u>7:05 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John F. Schaefer</u>		ADDRESS <u>401 Random Road</u>		DATE SIGNED <u>3-15-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY): <u>Burial</u>		DATE THEREOF: <u>Mar 16/55</u>		NAME OF CEMETERY OR CREMATORY: <u>St. Mary's</u>		LOCATION (City, town, or county) (State): <u>Balto. Md.</u>	
DATE REC'D BY LOCAL REGISTRAR: <u>3-16-55</u>		REGISTRAR'S SIGNATURE: <u>Dr. W. J. Schaefer</u>		24. FUNERAL DIRECTOR: <u>Stewart Mortuary</u> ADDRESS: <u>Balto. Md.</u>			



2359

02336

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 33

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Baltimore		STATE	Md.	
	MARYLAND		COUNTY	Carroll	
CITY (If outside corporate limits, write RURAL OR and give nearest town)			CITY (If outside corporate limits write RURAL and give nearest town)		
TOWN Owings Mills			TOWN Westminster		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
Rosewood School			230 E. Main		
3. NAME OF DECEASED:			4. DATE OF DEATH		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
Raymond Shipley Davis			March 20, 1955		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:		9. AGE last birthday:
Male	White	Married	March 19, 1911		44 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):			10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):
Shift Engineer					Carroll County
12. CITIZEN OF WHAT COUNTRY?			U.S.		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
William E. Davis			Pearl G. Shipley		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)			16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:
No			217-09-2042		230 E. Main Street Audrey K. Davis, Westminster, Md.

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				35 min.
(a) Asphyxiation due to being buried in soft Immediate cause DUE TO coal in silo				
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)				
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				none
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?
none		none		Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.)	21c. (City or town) (County) (State)	
		INJURY Coal silo	Owings Mills Balto. Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR
3-20-55 10:30 A.				While knocking coal loose, fell & was buried in coal.
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .				
SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED		
D. D. Caples		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 3-25-55		
M. D. ASSISTANT MEDICAL EXAM.				
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY
Burial		Mar. 23, 1955		Deer Park
LOCATION (City, town, or county) (State)		Carroll County		
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS
3-22-55		Mary B. Elmer		J. E. Meyers, Westminster, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 30 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2360

CERTIFICATE OF DEATH

Reg. Dist. No.

02337

1. PLACE OF DEATH: COUNTY Baltimore MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) 52 TOWN Catonsville HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hosp Catonsville, Md.				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Prince George CITY (If outside corporate limits, write RURAL and give nearest town) OR 4831 St. Barnabus Road TOWN Washington 21, D.C. 16X-2 STREET ADDRESS II II II II (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last) Arletta NMI DERRY				4. DATE (Month) (Day) (Year) OF DEATH: March 26 19 54			
5. SEX: Female		6. COLOR OR RACE: Caucasian		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow		8. DATE OF BIRTH: April 6, 1871	
9. AGE last birthday: 83 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife		10B. KIND OF BUSINESS OR INDUSTRY:		9. AGE last birthday: IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Virginia	
13. FATHER'S NAME: Richard Marshall				14. MOTHER'S MAIDEN NAME: Virginia Alder			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) no				16. SOCIAL SECURITY NO. ?		17. INFORMANT'S ADDRESS: Mrs. Louise M Marland - daughter Washington 21, D.C.	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 420.1 Myocardial infarction						3 wks	
ANTECEDENT CAUSE (S) DUE TO (B) Arteriosclerotic cardiovascular dis.						years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) associated with Senility							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Non-healing bed sores						1-2 mos.	
19A. DATE OF OPERATION: none		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? none			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from July 19, 1954 to Mar. 26, 19 55 that I last saw the deceased alive on Mar 26, 19 55 , and that death occurred at 6:30pm . SIGNATURE Lindsey D. Campbell ADDRESS M. D. Spring Grove State Hosp 3-26-55 <i>Lindsey D. Campbell</i>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/29		NAME OF CEMETERY OR CREMATORY Hillside		LOCATION (C. Y. town, or county) (State) Loudoun County Va	
DATE REC'D BY LOCAL REGISTRAR 3-27-55		REGISTRAR'S SIGNATURE V.E. Harry		24. FUNERAL DIRECTOR Hall Funeral Home		ADDRESS Super B. Simpson	

BUREAU V. S.

MAR 29 1935

RECEIVED

2361

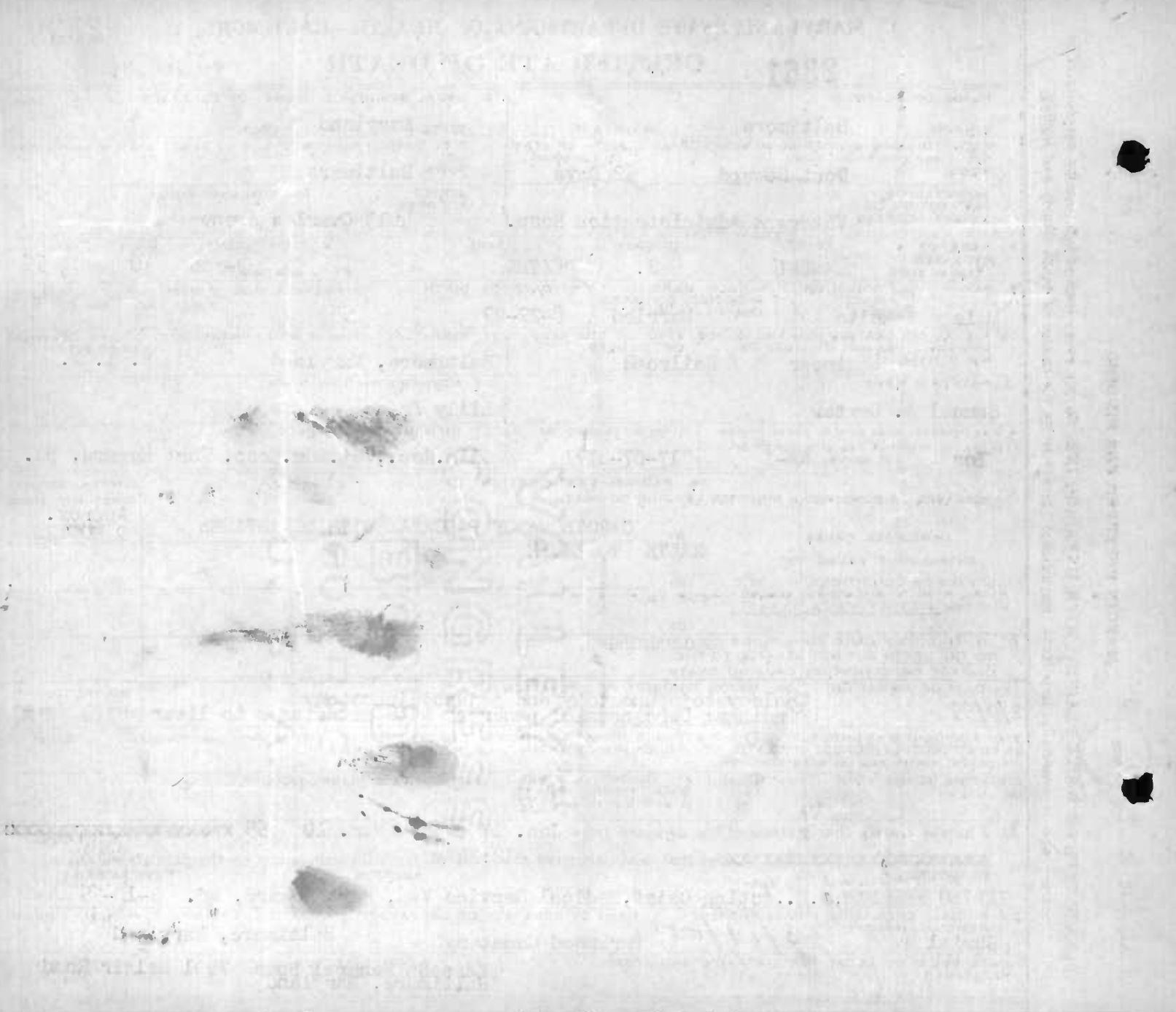
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN Fort Howard		52 Days		TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hosp.				STREET ADDRESS (If rural give location) 4013 Overlea Avenue			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
SAMUEL J. DEXTER				March 10 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
Male	White	Married	8-29-99	55			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Engineer		Railroad		Baltimore, Maryland		U. S. A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Samuel A. Dexter				Lilly Price			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
Yes WW-I		717-07-8791		Clin.Rec., Vet. Adm. Hosp. Fort Howard, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Approx. 9 MONTHS	
IMMEDIATE CAUSE (A) CARCINOMA OF PANCREAS WITH METASTASES TO LIVER							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
2/9/55		Cholecystojejunostomy and jejunojejunostomy Findings: Carcinoma of pancreas with metastases to liver					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
VA M.							
22. I hereby certify that I attended the deceased from Jan. 17, 1955 , to Mar. 10, 1955 , and that death occurred at 12:24 AM , from the causes and on the date stated above.							
SIGNATURE Irving Freeman				ADDRESS		DATE SIGNED	
IRVING FREEMAN, M.D., Acting Chief, Medical Service VAH, Fort Howard, Md.				3-10-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		3/14/55		Parkwood Cemetery		Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR'S ADDRESS			
MAR 12 1955		[Signature]		Lassahn Funeral Home 7401 Belair Road Baltimore, Maryland			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2362

MARYLAND STATE DEPARTMENT OF HEALTH

02339

CERTIFICATE OF DEATH

FOR MEDICAL EXAMINERS

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Port Howard		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Baltimore 3V01.4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital		STREET ADDRESS (If rural, give location) 635 W. Fayette Street	
3. NAME OF DECEASED (Type or Print) JOSEPH (First) E. (Middle) DICUS (Last)		4. DATE OF DEATH March 7, 19 55 (Month) (Day) (Year)	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH 11/11/87 67 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Produce Huckster		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	11. BIRTHPLACE (State or foreign country) Elkridge, Maryland
13. FATHER'S NAME John R. Dicus		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) WW I		14. MOTHER'S MAIDEN NAME Susan R. Watts	
16. SOCIAL SECURITY No. 216-08-8129 Unknown		17. INFORMANT AND ADDRESS Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 286.5 Immediate cause (a) SENILITY AND MALNUTRITION		INTERVAL BETWEEN ONSET AND DEATH UNKNOWN
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
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19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE William Carmine M.D.	DATE THEREOF Mar. 11, 1955	NAME OF CEMETERY OR CREMATORY Baltimore National	LOCATION (City, town, or county) Baltimore, Maryland	DATE SIGNED 3/15/55
23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE REC'D BY LOCAL REG. 3/15/55	REGISTRAR'S SIGNATURE A. H. Heluch Jr	24. FUNERAL DIRECTOR John N. Teufel & Son Funeral Home	ADDRESS 5311 Edmonds Ave., Baltimore, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A

TWO FOR ONE CERTIFICATE - Film G178 - 3/15/55 - mnb

Originally received on regular VSA15 - Should have been
medical examiner's certificate.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **02340**
 2363 ^{Item 2, Film 6179 4-5-55 et} **CERTIFICATE OF DEATH** Reg. Dist. No. **38**

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY BALTIMORE	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 55 TOWSON		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN TOWSON 417 Alabama Rd.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 CODD CONVALESCANT HOME				STREET ADDRESS COOD CONVALESCANT HOME			
3. NAME OF DECEASED: (First) (Middle) (Last) BERTHA LOUISE DODSON				4. DATE (Month) (Day) (Year) OF DEATH: March 26, 19 55			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: Oct. 21, 1872	9. AGE last birthday 82 yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife		10B. KIND OF BUSINESS OR INDUSTRY: Own Home		11. BIRTHPLACE (State or foreign country): Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: Mason Robert				14. MOTHER'S MAIDEN NAME: Helen Trumbower			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None		17. INFORMANT & ADDRESS: Family Information	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 450.0 Cardiac Failure							
ANTECEDENT CAUSE (S) DUE TO (B) Arteriosclerosis							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
2. I hereby certify that I attended the deceased from Nov. 2, 1955 , to March 26, 1955 , that I last saw the deceased alive on March 26, 1955 and that death occurred at 7:10 P M, from the causes and on the date stated above.							
SIGNATURE Lawrence C. Post M.D.		ADDRESS M. D. 6805 York Rd. Baltimore Md.		DATE SIGNED 3/27/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		DATE THEREOF Mar. 27, 1955		NAME OF CEMETERY OR CREMATORY Kelchner Funeral Home		LOCATION (City, town, or county) (State) Shickshinny, Luzerne Co., Pa.	
DATE REC'D BY LOCAL REGISTRAR Mar. 27, 1955		REGISTRAR'S SIGNATURE Mabel C. Gray		24. JUNEAN DIRECTOR John Burni Som,		ADDRESS Towson, Maryland	

BUREAU V. S.

MAR 29 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 **02341**
2364 **CERTIFICATE OF DEATH**

Reg. Dist. No. *44*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>6 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> <i>3Y01-4</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1934 W. Lafayette Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JAMES H. DOUGLASS</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>March 28 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>December 24, 1905</u>	9. AGE last birthday <u>49</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Receptionist</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Steamship Company</u>		11. BIRTHPLACE (State or foreign country): <u>Gloucester, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>James Douglass</u>				14. MOTHER'S MAIDEN NAME: <u>Susie Smith</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW-II</u>		16. SOCIAL SECURITY NO. <u>220-12-8672</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>292.6</u> (A) <u>RIGHT SIDED HEART FAILURE</u>						UNKNOWN	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <u>DUE TO CHRONIC PULMONARY EMBOLUS</u>						UNKNOWN	
<u>DUE TO SICKLE CELL ANEMIA</u>						LIFE	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 22, 1955</u> to <u>Mar. 28, 1955</u> , and that death occurred at <u>10:45 A.M.</u> from the causes and on the date stated above. SIGNATURE <u>William B. Vandegrift, M.D.</u> ADDRESS <u>M. DVAH, Fort Howard, Maryland</u> DATE SIGNED <u>3-29-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-1-55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery Baltimore, Maryland</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>3-29-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Charles R. Law Funeral Home</u>		ADDRESS <u>802 Madison Ave., Baltimore, Md.</u>	

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2365

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02342

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY BALTIMORE COUNTY CITY (If outside corporate limits, write RURAL and give nearest town) TOWSON HOSPITAL OR INSTITUTION OR STREET ADDRESS 8121 PLEASANT PLAINS RD.		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND COUNTY Balto. CITY (If outside corporate limits, write RURAL and give nearest town) TOWSON STREET ADDRESS (If rural, give location) 8121 PLEASANT PLAINS ROAD	
3. NAME OF DECEASED (Type or Print) PAULINE ENGLER		4. DATE OF DEATH MARCH 23, 1955	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOW	8. DATE OF BIRTH SEPT. 12, 1869
9. AGE last birthday 85 yrs.	10. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) GERMANY	12. CITIZEN OF WHAT COUNTRY USA
13. FATHER'S NAME ?		14. MOTHER'S MAIDEN NAME ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) NO		16. SOCIAL SECURITY No. NONE	
17. INFORMANT AND ADDRESS MRS THOMAS SINGMAN		18. SAME SAME	

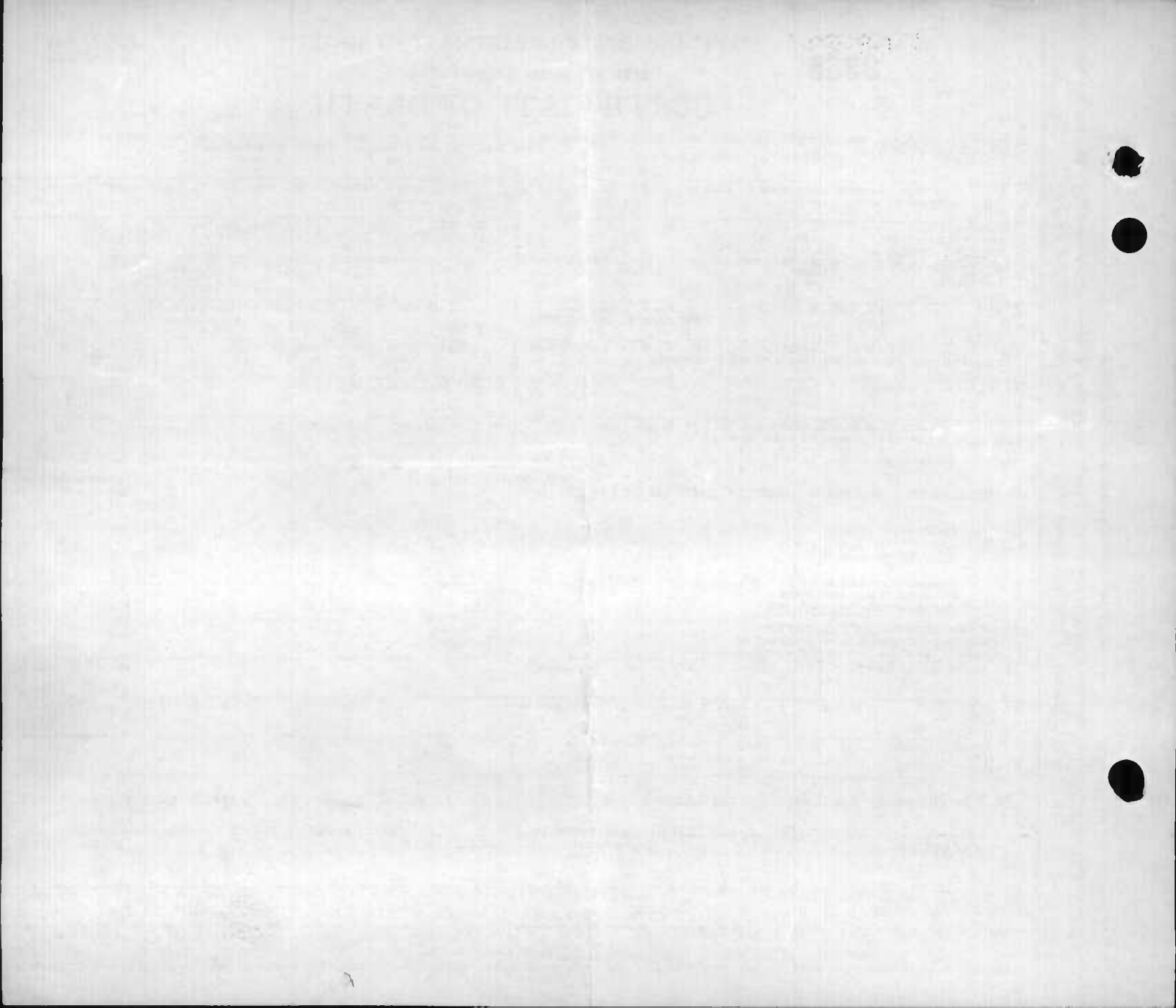
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
334X Immediate cause (a) Cerebral Arteriosclerosis			18 yr
Antecedent cause(s) (b) Aortic Regurgitation			14 yr
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Myocardial Infarction			3 yr
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION None	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) SUICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Dec 14, 1937, to 3/23, 1955, that I last saw the deceased alive on 3/23, 1955, and that death occurred at 10:17 m., from the causes and on the date stated above.

SIGNATURE Dr. Daniel Miller MD ADDRESS 4570 Stanford Rd Balt 14-Md DATE SIGNED

23. BURIAL, CREMATION (Specify) **BURIAL** DATE **MARCH 26, 1955** NAME OF CEMETERY OR CREMATORY **MORELAND MEMORIAL** LOCATION (City, town, or county) **BALTIMORE COUNTY** (State)

DATE REC'D BY LOCAL REG 3/25/55 REGISTRAR'S SIGNATURE A. W. Hedrick 24. FUNERAL DIRECTOR & SONS INC. ADDRESS BALTIMORE MARYLAND Bay View



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2366 CERTIFICATE OF DEATH

02343

Reg. Dist. No. 48

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
<u>X</u> TOWN <u>Fort Howard</u>	<u>8 Days</u>	STREET ADDRESS (If rural give location) <u>1325 Shield Place, Baltimore 17</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>1325 Shield Place, Baltimore 17</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>ROBERT HENRY EPPS</u>		<u>March 8, 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>April 21, 1893</u>
9. AGE last birthday <u>61</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>Norfolk, Virginia</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Odd Jobs</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Edward Epps</u>		14. MOTHER'S MAIDEN NAME: <u>Henrietta MN: Devall</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>WW-I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hospital, Fort Howard, Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
332X IMMEDIATE CAUSE (A) <u>ISCHEMIC INFARCTION, RIGHT CEREBRUM</u>		1 WEEK	
ANTECEDENT CAUSE (B) <u>THROMBOSIS, RIGHT ANTERIOR CEREBRAL ARTERY</u>		1 WEEK	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb. 28 1955</u> , to <u>Mar. 8, 1955</u> , and that death occurred at <u>4:30 A.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>William B. VanDeGrift</u>		ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u>	
DATE SIGNED <u>3-8-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/12/1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>MAR 12 1955</u>		REGISTRAR'S SIGNATURE <u>Arthur H. Hahn</u>	
24. FUNERAL DIRECTOR <u>Arlington S. Phillips</u>		ADDRESS <u>1808 N. Monroe St. Baltimore 17, Md.</u>	

STATE DEPARTMENT OF HEALTH

TO THE HONORABLE SECRETARY OF THE STATE DEPARTMENT OF HEALTH
FROM THE HONORABLE SECRETARY OF THE STATE DEPARTMENT OF HEALTH
SUBJECT: [Illegible]

[The following text is mirrored and largely illegible due to bleed-through from the reverse side of the page. It appears to be a formal communication or report.]

RECEIVED STATE DEPARTMENT OF HEALTH

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2367

CERTIFICATE OF DEATH

02319

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Anne Arundel</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u>	LENGTH OF STAY (in this place) <u>7 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mayo</u>	<u>02x-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove Hosp</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Virginia</u>	(Middle) <u>May</u>	(Last) <u>Buans</u>	OF DEATH: <u>Mar 16 1958</u>
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>5-10-1877</u>
		9. AGE last birthday <u>77</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Hv.</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Md.</u>
13. FATHER'S NAME: <u>George Gardner</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>-</u>	
17. INFORMANT & ADDRESS: <u>Hosp. Records</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>			<u>2 mo</u>
ANTECEDENT CAUSE (B) <u>Arterio sclerotic C.V. Dis</u>			<u>-</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile Psychosis</u>			<u>7 yrs</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 13, 1948</u> to <u>Mar 16, 1958</u> , that I last saw the deceased alive on <u>Mar 16, 1958</u> , and that death occurred at <u>4 15 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Frederick L. Phillips</u>		DATE SIGNED <u>3/16/58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>St. Andrews</u>	
DATE THEREOF <u>3-18-58</u>		LOCATION (City, town, or county) (State) <u>Mayo, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/16/58</u>		24. FUNERAL DIRECTOR ADDRESS <u>T. A. Hardesty & Son, Mayo, Md.</u>	
REGISTRAR'S SIGNATURE <u>T. E. Harry</u>			

RECEIVED

MAR 18 1955

BUREAU V. S.

MARYLAND

2368

02344
STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH COUNTY Balto. MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) near Randallstown		CITY (If outside corporate limits, write RURAL and give nearest town) near Randallstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Marriottsville Rd.		STREET ADDRESS (If rural, give location) Marriottsville Rd.	
3. NAME OF DECEASED (Type or Print) MILDRED F. FAULKNER		4. DATE OF DEATH (Month) Mar. (Day) 9. (Year) 1955	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) married	8. DATE OF BIRTH June 16, 1905
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home	9. AGE last birthday 49 yrs.
11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME George W. Loudenslager		14. MOTHER'S MAIDEN NAME Katherine France	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) none		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS Mr. Gene Faulkner - Marriottsville Rd.			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
442X Immediate cause		(a) CEREBRAL VASCULAR ACCIDENT	1 DAY
Antecedent cause(s)		(b) HYPERTENSIVE C.V. DISEASE, SEVERE & RENAL INSUFFICIENCY	5 YEARS
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		(c)	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **April**, 19**51**, to **MARCH 9**, 19**55**, that I last saw the deceased alive on **MARCH 9**, 19**55**, and that death occurred at **2 P.** m., from the causes and on the date stated above.

SIGNATURE **Thomas E. Wheeler** (Degree or title) **Md.** ADDRESS **Randallstown - Md.** DATE SIGNED **3-10-55**

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE 3/13/55	NAME OF CEMETERY OR CREMATORY Ward's Chapel	LOCATION (City, town, or county) Balto., Co., Md.	(State)
DATE REC'D BY LOCAL REG. 3/11/55	REGISTRAR'S SIGNATURE R. W. Hendrich	24. FUNERAL DIRECTOR Mr. J. C. Liskner	ADDRESS Stons-Balto 17 Md.	

MARGIN RESERVED FOR BINDING

2320

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Halethorpe LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4518 Spring Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Belts.
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Halethorpe 51
STREET ADDRESS (If rural, give location) 4518 Spring Ave.

3. NAME OF DECEASED: (Type or Print)

(First) Harry E. (Middle) E. (Last) Sender

4. DATE OF DEATH:

(Month) Mar. (Day) 30 (Year) 1955

5. SEX:

Male

6. COLOR OR RACE:

Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED,

Married

8. DATE OF BIRTH:

Feb. 4, 1896

9. AGE last birthday:

59 yrs.

10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Signal Depot

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Signal Depot

10b. KIND OF BUSINESS OR INDUSTRY:

Signal Depot

11. BIRTHPLACE (State or foreign country)

Howard Co. Md.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Unknown

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

Yes WW I

16. SOCIAL SECURITY No.:

60-11-1

17. INFORMANT & ADDRESS:

Mrs. E. E. Sender
4518 Spring Ave.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

434.1

Immediate cause

(a) DUE TO

MYOCARDIAL INFARCTION

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

CONGESTIVE HEART FAILURE

(c)

INTERVAL BETWEEN ONSET AND DEATH

1 WEEK

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 24 MARCH 55, 1955, to 30 MARCH 55, 1955, that I last saw the deceased alive on 30 MARCH 55, 1955, and that death occurred at 8 P m., from the causes and on the date stated above.

SIGNATURE

(DECREE OR TITLE) ADDRESS

DATE SIGNED

George E. Guleau M.D. Chesapeake 27 md 2 April 55

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(STATE)

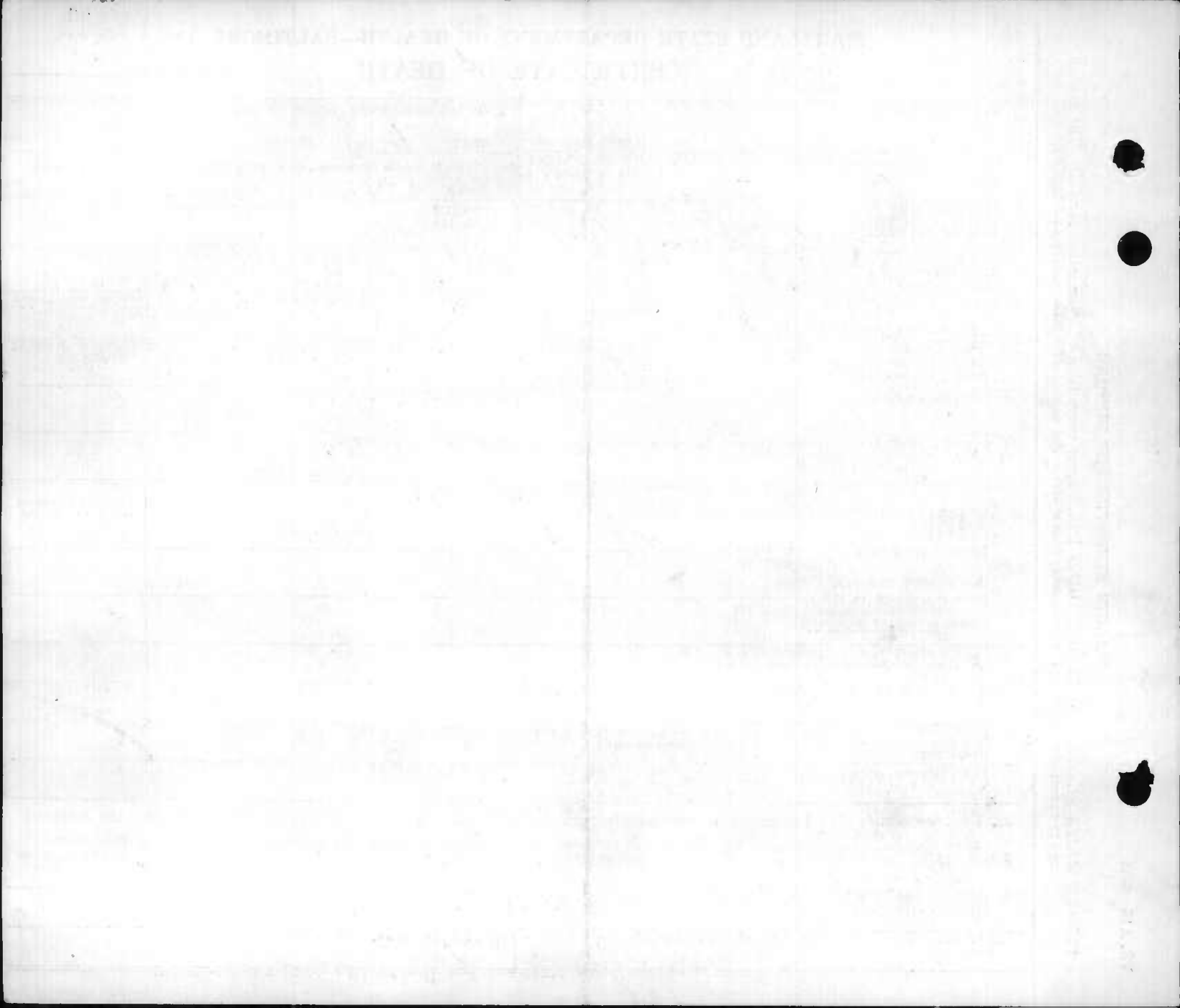
DATE REC'D BY LOCAL REG. 9-4-55

REGISTRAR'S SIGNATURE G. W. ...

24. FUNERAL DIRECTOR

Funeral Home

MARGIN RESERVED FOR BINDING



2369

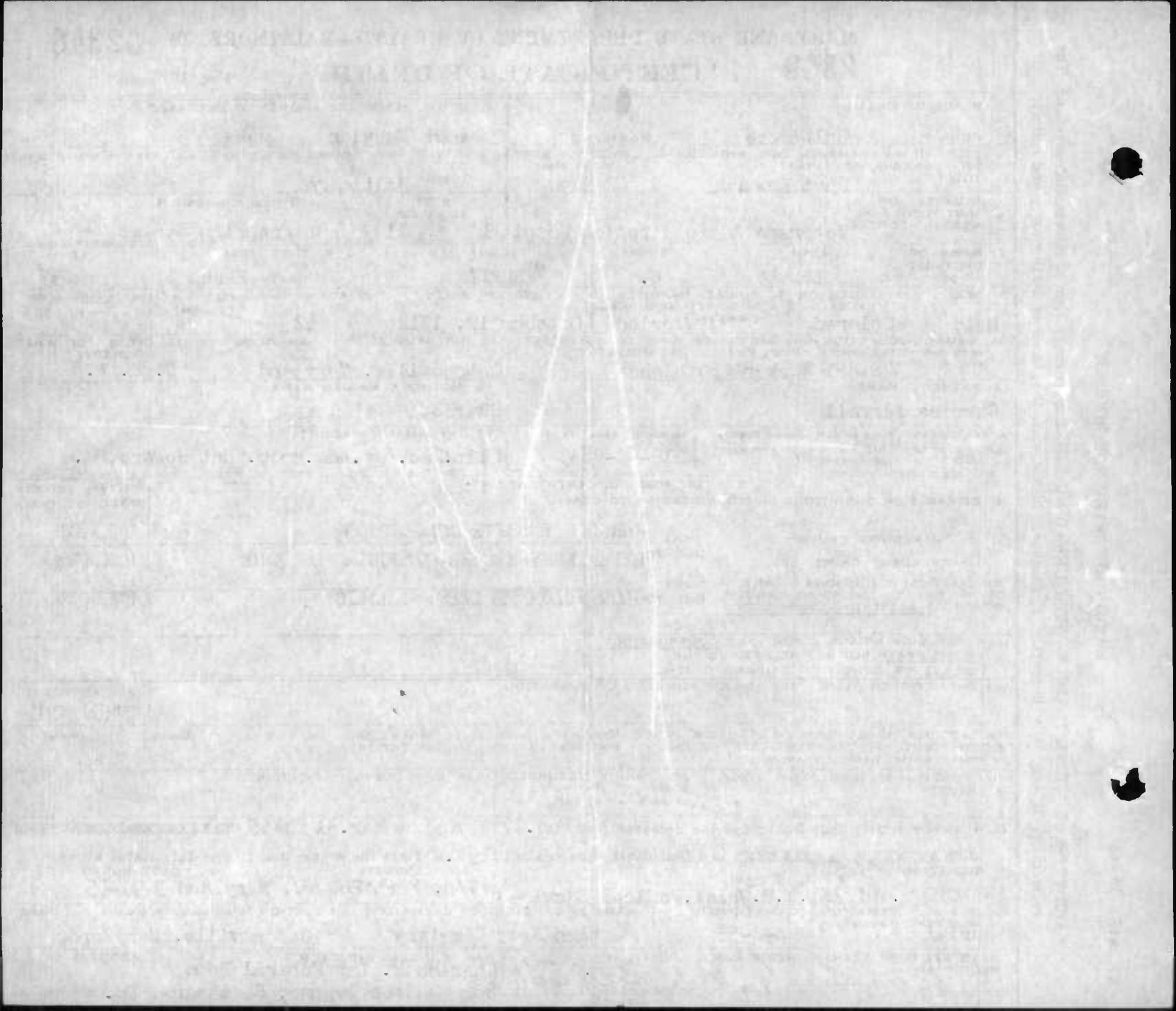
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Fort Howard</u>	LENGTH OF STAY (in this place) <u>42 Days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3801.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>1109 West Franklin Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>COLUMBUS H. FERRELL</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>March 31 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>October 12, 1912</u>
9. AGE last birthday <u>42</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steel Worker</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Bethlehem Steel</u>	
11. BIRTHPLACE (State or foreign country): <u>Catonsville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Charles Ferrell</u>		14. MOTHER'S MAIDEN NAME: <u>Charlotte Williams</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>215-03-9833</u>	
17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp. Fort Howard, Md.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>CHRONIC PASSIVE CONGESTION</u>			<u>UNKNOWN</u>
ANTECEDENT CAUSE (S) DUE TO <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>			<u>UNKNOWN</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>GLOMERULONEPHRITIS, CHRONIC</u>			<u>UNKNOWN</u>
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 17</u> , 19 <u>55</u> , to <u>Mar. 31</u> , 19 <u>55</u> , and that death occurred at <u>1:25 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Francis G. Dickey</u>		ADDRESS <u>VAH, Fort Howard, Maryland 3-31-55</u>	
FRANCIS G. DICKEY, M.D. Chief, Medical Service			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Western Star Cemetery</u>	
DATE THEREOF <u>4-4-55</u>		LOCATION (City, town, or county) (State) <u>Catonsville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-21-55</u>		REGISTRAR'S SIGNATURE <u>G. W. Redwood</u>	
24. FUNERAL DIRECTOR <u>Charles R. Law Funeral Home</u>		ADDRESS <u>802 Madison Avenue, Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

02347

2370

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY BALTIMORE		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE MARYLAND		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN FORT HOWARD		LENGTH OF STAY (In this place) D.O.A.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN BALTIMORE		3V01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS VETERANS ADMINISTRATION HOSPITAL				STREET ADDRESS 1805 Hope Street		(If rural, give location)	
3. NAME OF DECEASED (Type or Print) Joseph		(First) L.		(Last) Field		4. DATE OF DEATH (Month) 8:30 (Day) 1 (Year) 1955 March 6	
5. SEX Male		6. COLOR OR RACE White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH 1/6/91	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Armored Carrier		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Field				14. MOTHER'S MAIDEN NAME Rose McKeever			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. 213-06-8590		17. INFORMANT AND ADDRESS Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

422.1

Immediate cause

(a) **CEREBRAL ACCIDENT**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE**

(c)

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

DIABETES MELLITUS

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)
BurialDATE THEREOF
3/9/55NAME OF CEMETERY OR CREMATORY
Baltimore NationalLOCATION (City, town, or county)
Baltimore, Maryland

(State)

DATE REC'D BY LOCAL REG.
3-7-55REGISTRAR'S SIGNATURE
A. W. Field

24. FUNERAL DIRECTOR

Sanders & Sons, Inc.

ADDRESS

Baltimore, Maryland

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

2371

CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED (Type or Print)			2. DATE OF DEATH		
ANNA H. FLINTHAM			March 24, 1955		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>Balto. Co.</i>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland		
B. FULL NAME OF HOSPITAL OR INSTITUTION 90 Mercy Villa			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 3401.4		
c. Length of stay in Baltimore Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) Mt. St. Agnes College		
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) single	8. DATE OF BIRTH Aug. 1860	9. AGE (In years last birthday) 94	10. Under 1 Year Months: Days 10. Under 24 Hours Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Never employed			10B. KIND OF BUSINESS OR INDUSTRY --		
11. BIRTHPLACE (State or foreign country) Philadelphia, Pennsylvania			12. CITIZEN OF WHAT COUNTRY? U. S. A.		
13. FATHER'S NAME WILLIAM FLINTHAM			14. MOTHER'S MAIDEN NAME Caroline King		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		
17. INFORMANT Mrs. Oliver K. Reed, Philadelphia, Penna.			4310 Walnut Street		

18. 422.1 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arterio sclerotic cardio vascular disease DUE TO		INTERVAL BETWEEN ONSET AND DEATH 5 yrs.
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. DUE TO		
(C)		

II
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.

IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., home or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Approximately March 24</u> 1954 to <u>March 24</u> 1955, that (I) (we) last saw the deceased alive on <u>March 24</u> 1955, and that death occurred at <u>7:30 A.</u> m., from the causes and on the date stated above.				
23A. SIGNATURE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23B. ADDRESS 11 East Chase Street #2		23C. DATE SIGNED 3/25/55
24A. BURIAL, CREMATION, REMOVAL (Specify) burial	24B. DATE 3/26/55	24C. NAME OF CEMETERY OR CREMATORY Old St. Ann's Cemetery	24D. LOCATION (City, town, or county) (State) Middletown, Delaware	
DATE RECEIVED BY LOCAL REGISTRAR 3/26/55	REGISTRAR'S SIGNATURE A. W. Hedrick	25. FUNERAL DIRECTOR ADDRESS 1217 St. Paul Street		

THIS IS A PERMANENT RECORD. PLEASE TYPE RITE WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. The Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and leg. HIS CERTIFICATE MUST BE FILED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

02349

MARYLAND

STATE DEPARTMENT OF HEALTH

2372

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 TOWN CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTO.</u> <u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 RECEDO KNOLL</u>		STREET ADDRESS (If rural, give location) <u>4104 WALKAD AVE.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>M.</u> (Middle) <u>ELIZABETH</u> (Last) <u>FORRESTER</u>	4. DATE OF DEATH	(Month) <u>3</u> (Day) <u>6</u> (Year) <u>1955</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>SEPT. 11, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>	9. AGE last birthday <u>81</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>WILLIAM KOESTER</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET DIETERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Bernard Forrester - 4104 Walkad Ave.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
331X Immediate cause (a) <u>Cerebral Vascular Accident</u>			<u>48 hrs.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Hypertension</u>			<u>10 yrs.</u>
(c) <u>Chronic Coronary Disease</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Recurrent Congestive Heart Failure</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>March 4, 1955</u> , to <u>March 6, 1955</u> , that I last saw the deceased alive on <u>March 5, 1955</u> , and that death occurred at <u>5:30 p.m.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Nelson McKay</u> (Degree or title)		ADDRESS <u>6014 EDWARDS AVE</u> DATE SIGNED <u>3/8/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>3-9-55</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cms.</u>	LOCATION (City, town, or county) <u>Brooklyn Md.</u>
DATE REC'D BY LOCAL REG. <u>3-9-55</u>	REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	24. FUNERAL DIRECTOR ADDRESS <u>Only Funeral Home - Catonsville, Md.</u>	

MARGIN RESERVED FOR BINDING

RECEIVED

MAR 11 1955

BUREAU V. S.

2373

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place) <u>9 MO.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Paradise Nursing Home</u>		<u>Paradise - Altmont Aves</u>		STREET ADDRESS (If rural give location) <u>723 E. Belvedere Ave</u>			
3. NAME OF DECEASED: (First) <u>Rhoda</u> (Middle) <u>F.</u> (Last) <u>Fox</u>				4. DATE OF DEATH: (Month) <u>March</u> (Day) <u>2</u> (Year) <u>1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Oct 11 1872</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>At home</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>-</u>		9. AGE last birthday: <u>82</u> yrs. Months Days Hours Min.		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>George W Green</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>				14. MOTHER'S MAIDEN NAME: <u>Theresa Duffy</u>			
16. SOCIAL SECURITY No.: <u>-</u>				17. INFORMANT & ADDRESS: <u>Mrs Ida Brooks 723 E Belvedere Ave</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>450.0</u>		
Immediate cause (a) <u>Myocardial failure</u>		<u>72 hrs</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the <u>underlying cause last.</u> (b) <u>Arterio sclerosis, generalized, severe</u>		<u>Unknown</u>
(c) <u>Arterio sclerosis, generalized, severe</u>		

11. OTHER SIGNIFICANT CONDITIONS				20. AUTOPSY ?			
Conditions contributing to the death but not related to the disease or condition causing death.				Yes <input type="checkbox"/> No <input type="checkbox"/>			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION					
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			

22. I hereby certify that I attended the deceased from 1-17-55, 1955, to 3-2-55, 1955, that I last saw the deceased alive on 3-1-55, 1955, and that death occurred at 7:30 AM, from the causes and on the date stated above.

SIGNATURE Stephen Lee Hagness M.D. (Degree or title) Catonsville 28, Md ADDRESS 3-2-55 DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Mar 5-55</u>	<u>St Marys (Hamden)</u>	<u>Balto. Md</u>	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3-3-55</u>	<u>R. W. Adams</u>	<u>Burgess Funeral Home</u>	<u>3631 Falls Rd</u>	
		<u>Drove</u>	<u>by Niece Burgess Jr.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ACAWAM BOND

100 COTTON FINE

2374

CERTIFICATE OF DEATH

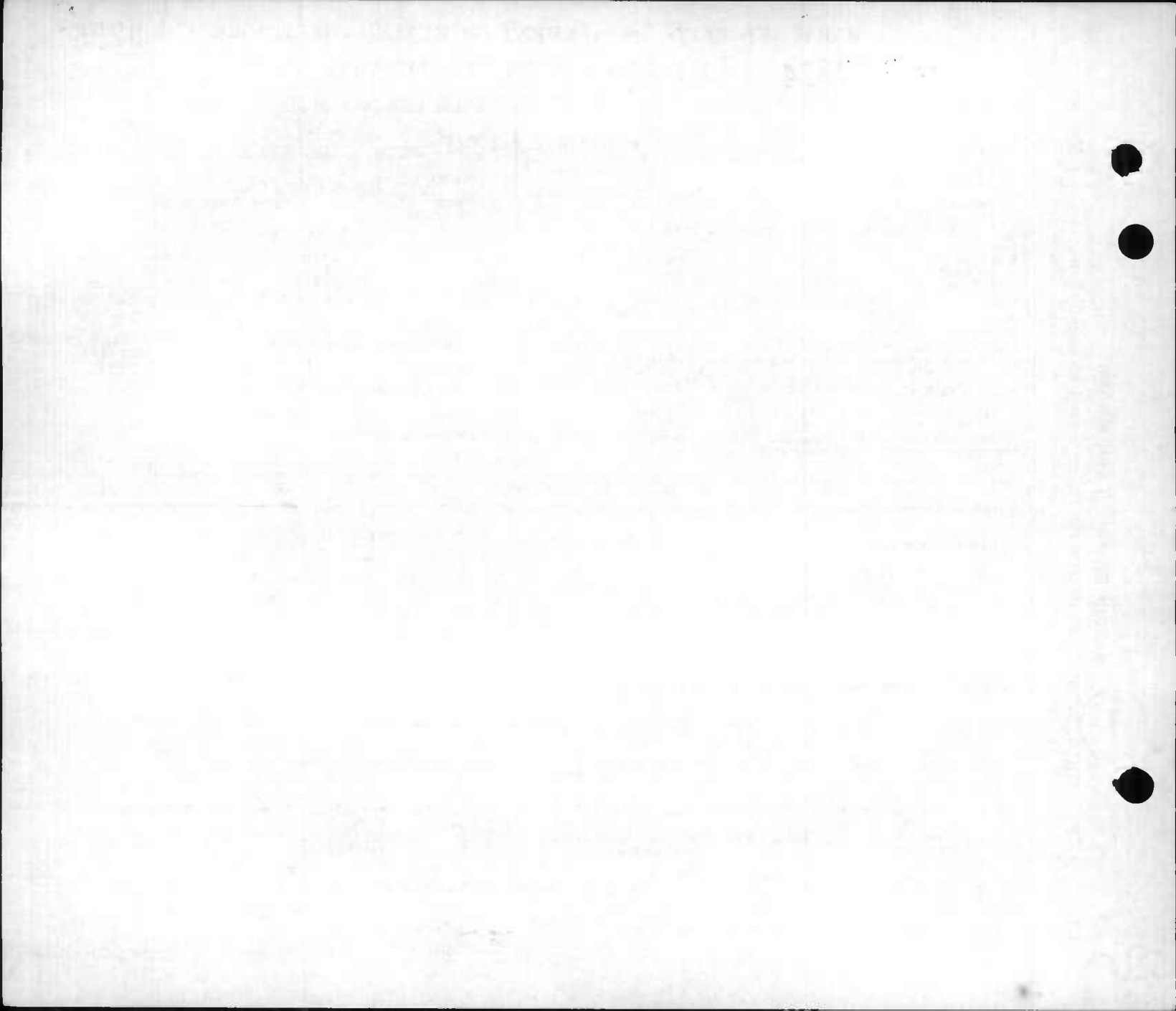
Reg. Dist. No.

44

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct
are is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Sparrows Point</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1316 Forrest Road</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY _____ CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sparrows Point</u> STREET ADDRESS (If rural give location) <u>1316 Forrest Road</u>	
3. NAME OF DECEASED: (First) <u>FRED</u> (Middle) <u>RAYMOND</u> (Last) <u>FOY, SR.</u> (Type or Print)		4. DATE OF DEATH: (Month) <u>March</u> (Day) <u>5</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>March 28, 1906</u>
9. AGE last birthday: <u>48</u> yrs.		10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>Burner</u>	
11. BIRTHPLACE (State or foreign country): <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John W. Foy</u>		14. MOTHER'S MAIDEN NAME: <u>Emma G. McCracklin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: _____	
17. INFORMANT & ADDRESS: <u>Mrs. Virgie M. Foy 1316 Forrest Road-19</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>157X</u> Immediate cause (a) <u>Generalized Carcinomatosis</u> Antecedent causes (s) (b) <u>Carcinoma of Head of Pancreas</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) _____		Interval Between Onset And Death <u>2 mos</u> <u>6 mos</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: _____		19b. MAJOR FINDINGS OF OPERATION _____	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		21. ACCIDENT SUICIDE HOMICIDE (Specify) _____	
22. I hereby certify that I attended the deceased from <u>July 10, 1954</u> to <u>Mar. 5, 1955</u> , that I last saw the deceased alive on <u>Mar. 5, 1955</u> , and that death occurred at <u>5:00 PM</u> , from the causes and on the date stated above.		23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> DATE THEREOF <u>March 8, 1955</u> NAME OF CEMETERY OR CREMATORY <u>Oak Lawn</u> LOCATION (City, town, or county) (State) <u>Colgate, Md.</u>	
24. FUNERAL DIRECTOR <u>Ullrich Funeral Home 2112 Dundalk Ave.</u>		25. DATE REC'D BY LOCAL REGISTRAR <u>3-8-55</u> REGISTRAR'S SIGNATURE <u>[Signature]</u>	



MARYLAND

2375

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RANDALLSTOWN-</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>RANDALLSTOWN-</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MARRIOTT SUITE ROAD</u>		STREET ADDRESS (If rural, give location) <u>MARRIOTT SUITE ROAD -</u>	
3. NAME OF DECEASED (First) <u>RICHARD</u> (Middle) <u>PETER</u> (Last) <u>GANJON</u>		4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>24</u> (Year) <u>1955</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, <u>MARRIED</u> , WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>FEB 10-1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BOOK-BINDER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BOOK-BINDER</u>	9. AGE last birthday <u>52</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>ESSEN - GERMANY</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>GEORGE L. GANJON</u>		14. MOTHER'S MAIDEN NAME <u>EMILIE OPITZ</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>service</u>	
17. INFORMANT, AND ADDRESS <u>MRS HATTIE E. GANJON - RANDALLSTOWN MD</u>			

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
(a) <u>151X</u> Immediate cause <u>CARCINOMA OF STOMACH</u>			<u>18 MONTHS</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last			
(c) II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>MAY 7-1954</u>	19b. MAJOR FINDINGS OF OPERATION <u>CARCINOMA OF STOMACH - GASTRO-ENTEROSTOMY -</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF offices bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from JUNE 1, 1953, to MARCH 24, 1955, that I last saw the deceased

on MARCH 24, 1955, and that death occurred at 2:15 A.M., from the causes and on the date stated above.
SIGNATURE Thomas E. Wheeler MD ADDRESS Randallstown, Md. DATE SIGNED 3-24-55

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE 3-26-55 NAME OF CEMETERY OR CREMATORY Ward's Chapel Cemetery LOCATION (City, town, or county) (State) Baltimore Co. Md.

DATE REC'D BY LOCAL REG. 3/25/55 REGISTRAR'S SIGNATURE Thos. E. Wheeler 24. FUNERAL DIRECTOR Ellsworth Armacost ADDRESS Ellsworth Armacost 4600 Liberty Heights Ave

BUREAU V. S.

APR 7 1955

RECEIVED

2376

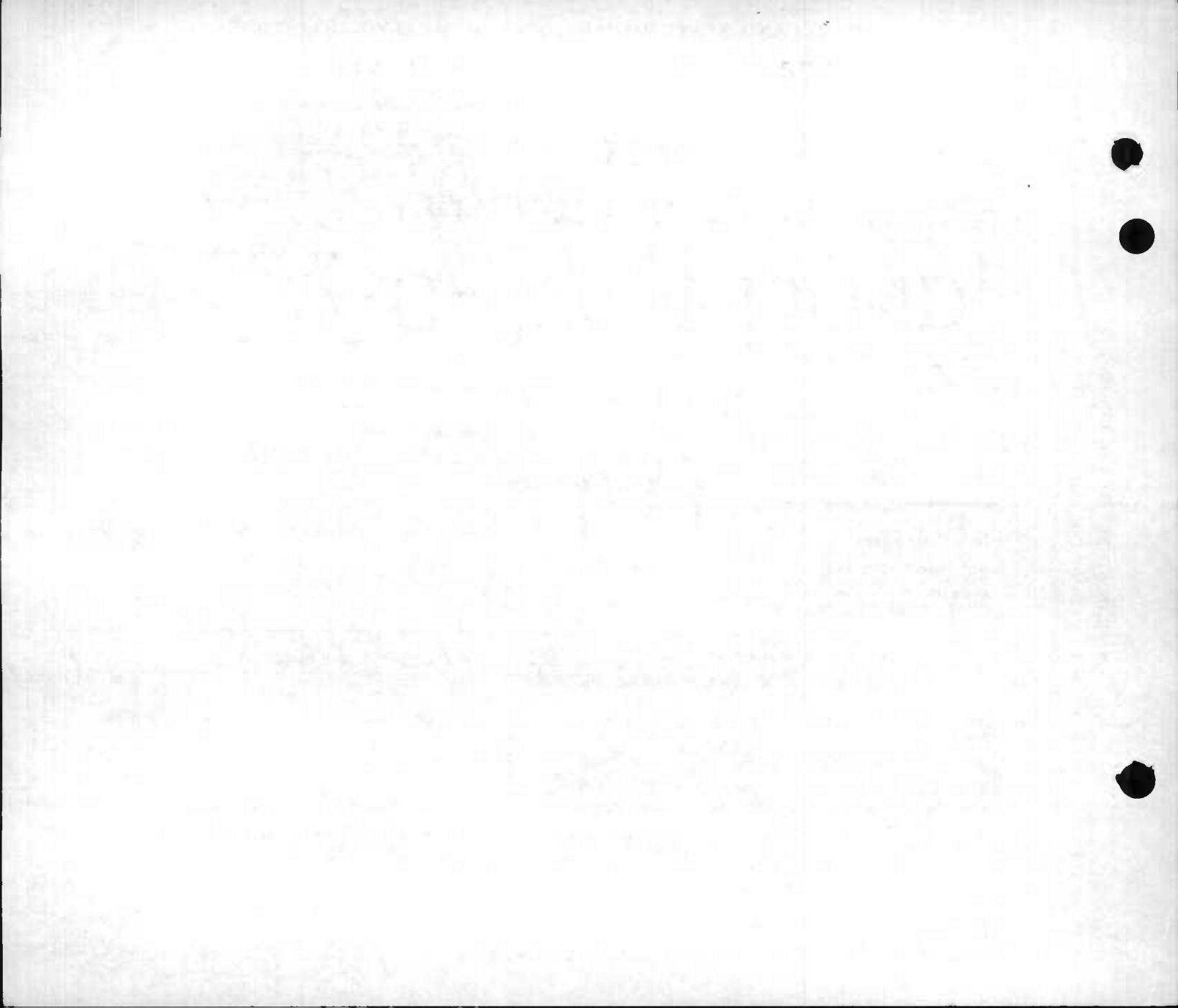
CERTIFICATE OF DEATH

Reg. Dist. No. *31*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Balto</i>		MARYLAND		STATE <i>Md</i>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Woodlawn</i>		LENGTH OF STAY (in this place) <i>14 yrs</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Woodlawn</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>90 Fugelsburg Home</i>				STREET ADDRESS (If rural give location) <i>6811 Campfield Rd</i>			
3. NAME OF DECEASED: (Type or Print) <i>Pauline</i> (First) (Middle) (Last) <i>Block</i>				4. DATE OF DEATH: <i>Mar. 26</i> (Day) (Year) <i>1955</i>			
5. SEX: <i>7</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH: <i>May 26, 1871</i>	9. AGE last birthday: <i>83</i> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>None</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>None</i>		11. BIRTHPLACE (State or foreign country): <i>Germany</i>		12. CITIZEN OF WHAT COUNTRY: <i>U.S.</i>	
13. FATHER'S NAME: <i>Unknown</i>				14. MOTHER'S MAIDEN NAME: <i>Unknown</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unk.) <i>No</i>		16. SOCIAL SECURITY No.: <i>None</i>		17. INFORMANT & ADDRESS: <i>Records Fugelsburg Home</i>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
<p><i>420.0</i> Immediate cause (a) <i>(1) Arterio-Sclerotic Heart Disease</i> Antecedent causes (s) (b) <i>with - Hypertension</i> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)</p>						<i>15 yrs</i>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <i>- Generalized Arterio-Sclerosis</i>						<i>10 yrs</i>	
19a. DATE OF OPERATION: <i>None</i>				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) <i>SUICIDE</i>		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Dec. 18, 1940</i> , to <i>Mar 26, 1955</i> , that I last saw the deceased alive on <i>Mar 24, 1955</i> , and that death occurred at <i>5:45 A.M.</i> , from the causes and on the date stated above.							
SIGNATURE <i>Earl L. Chambers</i>		(Degree or title) <i>M.D.</i>		ADDRESS <i>4108 Liberty Hts. A. Baltimore</i>		DATE SIGNED <i>7 Mar 3 36 55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>3/28/55</i>		NAME OF CEMETERY OR CREMATORY <i>FORT LINCOLN</i>		LOCATION (City, town, or county) (State) <i>WASH. D.C.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>March 26 1955</i>		REGISTRAR'S SIGNATURE <i>R.W.</i>		24. FUNERAL DIRECTOR <i>Chas. A. Germany</i>		ADDRESS <i>6067 Stanford Rd</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2377

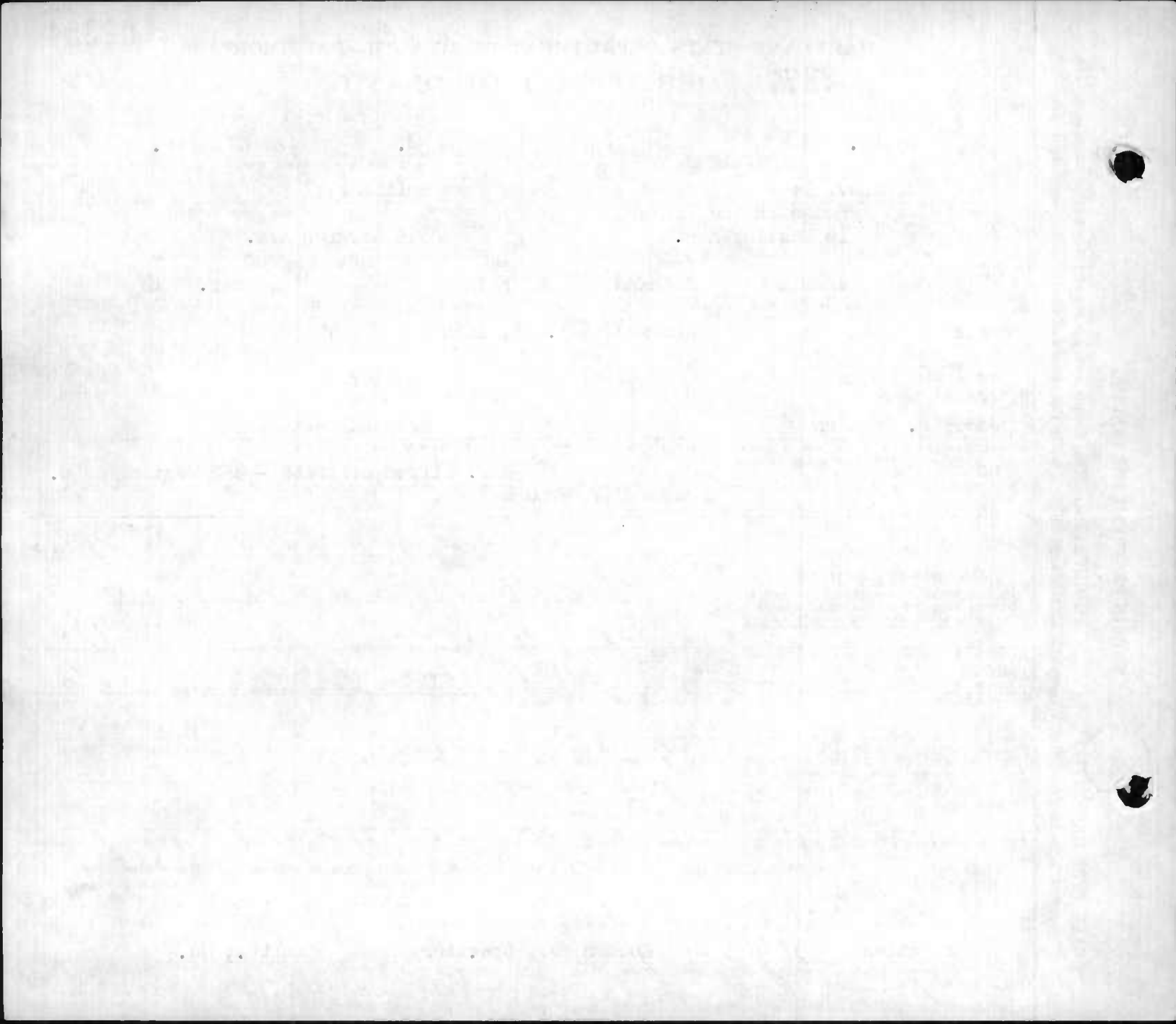
CERTIFICATE OF DEATH

Reg. Dist. No.

02354

20

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY Balto.	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 TOWN Catonsville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 House in the Pines 16 Fusting Ave.				STREET ADDRESS (If rural give location) 914 Belgian Ave.			
3. NAME OF DECEASED: (First) (Middle) (Last) JENNIE MULHERN GRIFFITH				4. DATE (Month) (Day) (Year) OF DEATH: Mar. 14 1955			
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify): Widowed	8. DATE OF BIRTH: Aug. 25, 1884	9. AGE last birthday: 70 yrs.	IF UNDER 1 YEAR: Months	IF UNDER 1 YEAR: Days	IF UNDER 24 HRS. Hours Mln.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): New York		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: James P. Mulhern				14. MOTHER'S MAIDEN NAME: Mary Hafferty			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): no (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: Mr. Alfred Griffith - 352 Westshire Rd.		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) GENERALIZED ARTERIOSCLEROSIS						10 1/2 yrs	
ANTECEDENT CAUSE (S) DUE TO AORTIC STENOSIS							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) CHRONIC GLOMERULONEPHRITIS						40 1/2 yrs	
DUE TO SPLEENOMEGALY						1 1/2 yrs	
(C) CEREBRO-CORTICAL ATROPHY						1 yr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 12/3, 1953 , to 3/13, 1955 , that I last saw the deceased alive on 10 P.M. , and that death occurred at 10 P.M. from the causes and on the date stated above.							
SIGNATURE Samuel R. Skylesian		ADDRESS 2212 South Road Baltimore 7, Md.		DATE SIGNED 3/15/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		DATE THEREOF 3/16/55		NAME OF CEMETERY OR CREMATORY Loudon Park Crematory		LOCATION (City, town, or county) (State) Balto., Md.	
DATE REC'D BY LOCAL REGISTRAR 3-16-55		REGISTRAR'S SIGNATURE R. W. Hedden		24. FUNERAL DIRECTOR Wm. J. Pickens		ADDRESS Louis Beach, Md.	



2378

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<u>X</u> <u>Parkville</u>				<u>Parkville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>2902 Onyx Road #14</u>				<u>2902 Onyx Road #14</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Mr. Strother E. Grim</u>				<u>March 11 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>married</u>	<u>March 7-1900</u>	<u>55</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Gas Fitter</u>		<u>Gas & Elec. Co.</u>		<u>Winchester, Virginia</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Mr. Samuel Grim</u>				<u>Emily Sherman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
		<u>212-05-3914</u>		<u>Mrs. Alice E. Grim, 2902 Onyx Road #14</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Carcinoma of Pharynx</u>						<u>3 yrs.</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City 'or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb 1, 1955</u> , to <u>March 11, 1955</u> , that I last saw the deceased alive on <u>March 6, 1955</u> , and that death occurred at <u>11 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Bronx Quercyn</u>		ADDRESS <u>4808 Harford Rd.</u>		DATE SIGNED <u>3/12/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Mar. 14-1955</u>		<u>Moreland Memorial Park</u>		<u>Baltimore Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Mar 12 1955</u>		<u>Leonard J. Ruck</u>		<u>Leonard J. Ruck, 5305 Harford Road #14</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Sawyer
4808 Harford Road

Please Call us when completed. HA 6 1460
Ruck Funeral Home.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02356

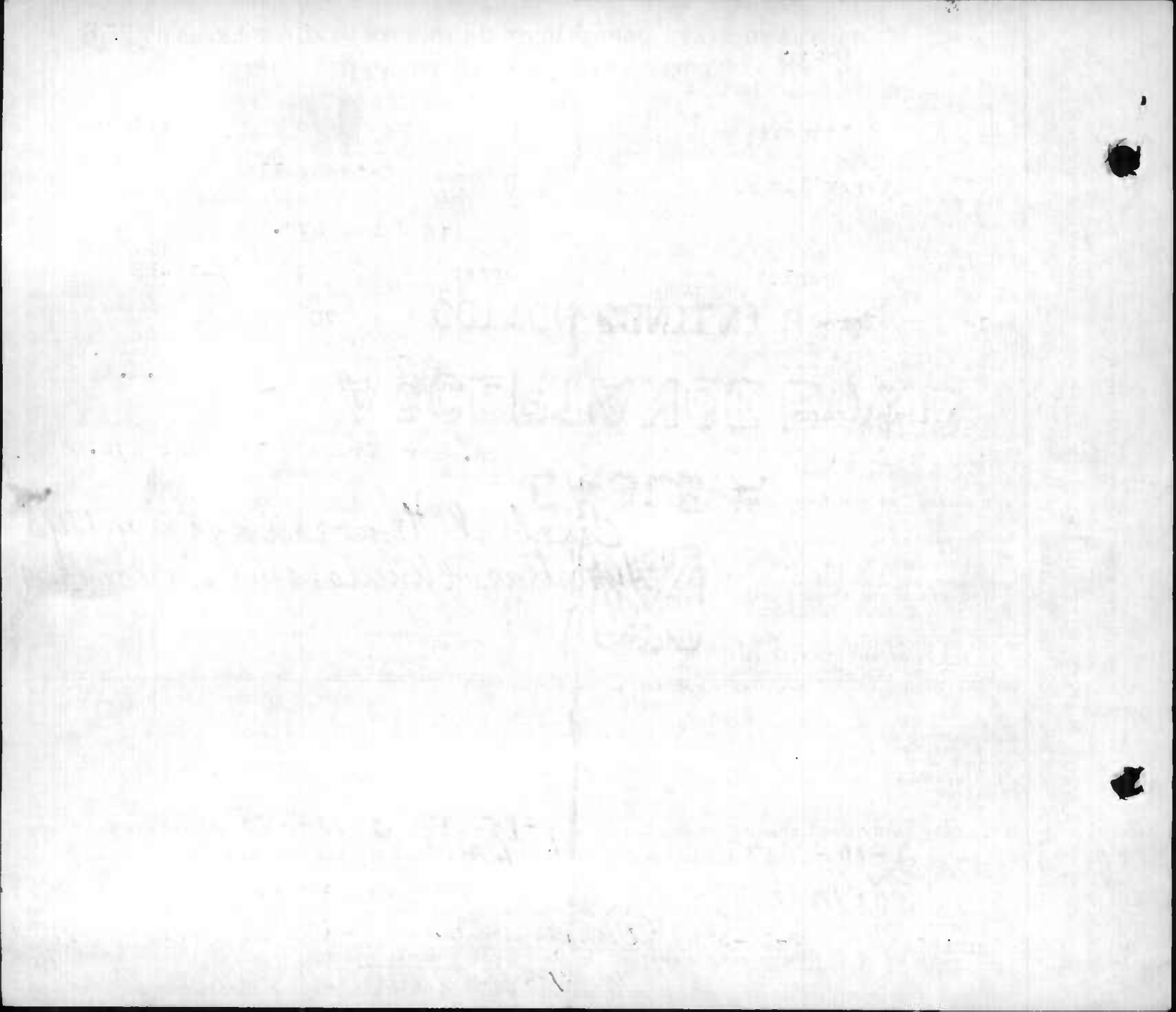
2379

CERTIFICATE OF DEATH

Reg. Dist. No. 30

Item 14, Film 178 3-17-55 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Md	COUNTY Baltimore
CITY (If outside corporate limits, write RURAL OR and give nearest town) 57 Catonsville	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 52 Catonsville	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00		STREET ADDRESS (If rural give location) 16 Jones Ave.	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) Charles	(Middle)	(Last) Gross	(Month) 3-10-55 (Day) 19 (Year)
5. SEX: Male	6. COLOR OR RACE: Colored	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH:
			9. AGE last birthday: 76 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Maryland
13. FATHER'S NAME: William Gross		14. MOTHER'S MAIDEN NAME: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT & ADDRESS: Mrs. Mary Gross 16 Jones Ave.	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) Cerebral Hemorrhage			4 days
ANTECEDENT CAUSE (B) Hypertensive Arterio-sclerosis			10 mo - 29 days
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 4-15-1954 to 3-10-1955 that I last saw the deceased alive on 3-10-1955 , and that death occurred at 10 A M, from the causes and on the date stated above.			
SIGNATURE C. F. Maloney		DATE SIGNED 3-10-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-14-55	
NAME OF CEMETERY OR CREMATORY Western Star		LOCATION (City, town, or county) (State) Catonsville Md	
DATE REC'D BY LOCAL REGISTRAR 12 1955		REGISTRAR'S SIGNATURE W. H. Hiden	
24. FUNERAL DIRECTOR W. H. Hiden		ADDRESS 578 W. Winter Lane - 28 -	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02357

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>20 Days</u>		OR TOWN <u>Baltimore</u> <u>3401-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>606 S. Smallwood Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>March 23, 1955</u>			
<u>HARRY M. HALL</u>							
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Divorced</u>	8. DATE OF BIRTH: <u>July 9, 1889</u>	9. AGE last birthday: <u>65</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Attendant</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>B. & O. R. R.</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Jefferson Hall</u>				14. MOTHER'S MAIDEN NAME: <u>Florenz MN: Shewbridge</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW-I</u>				16. SOCIAL SECURITY NO. <u>705-05-5890</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp. Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>163X CARCINOMA OF RIGHT LUNG</u>						UNKNOWN	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 3, 1955</u> , to <u>Mar. 23, 1955</u> , and that death occurred at <u>9:15 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. VandeGrift, M.D.</u>				ADDRESS <u>M. D. VAH, Fort Howard, Maryland 3-23-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-26-55</u>		NAME OF CEMETERY OR CREMATORY <u>Louden Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-28-55</u>		REGISTRAR'S SIGNATURE <u>A. W. Pyndick</u>		24. FUNERAL DIRECTOR <u>Wm. Tickner, North & Pennsylvania Aves.</u>		ADDRESS <u>Baltimore, Md.</u>	

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

IN THE STATE OF NEW YORK

County of _____

Town of _____

City of _____

State of _____

Decedent's Name _____

Age _____

Sex _____

Color _____

Marital Status _____

Occupation _____

Usual Residence _____

Place of Birth _____

Date of Birth _____

Usual Residence _____

Place of Birth _____

Date of Birth _____

Usual Residence _____

Place of Birth _____

Date of Birth _____

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2381

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. 02358

No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND <u>md</u>		STATE <u>md</u>		COUNTY <u>Balto</u> <input checked="" type="checkbox"/>	
CITY (If outside corporate limits, write RURAL OR nearest town) <u>Balto 20, Middle River</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Balto 20, Middle River</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>12000 Susquehanna Ave</u>				STREET ADDRESS (If rural, give location) <u>184199 Rk. 15, Susquehanna's</u>			
3. NAME OF DECEASED: (Type or Print) <u>Ellie Ann Tomlinette Hamper</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 29 1955</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <u>Married</u>	8. DATE OF BIRTH: <u>Feb 2, 1898</u>	9. AGE last birthday: <u>57</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>John Benda</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Benda</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: <u>219-10-0395</u>		17. INFORMANT & ADDRESS: <u>John T. Hamper (Husband)</u>			

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
322.1 Immediate cause		(a) DUE TO <u>Coronary occlusion</u>		<u>Immediate</u>	
Antecedent cause(s)		(b) DUE TO <u>Chronic alcoholism</u>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		(c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) (Min) <u>Mar 29 55 39 A.M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Wm. J. Hamper M.D.</u>		M. D. <u>Wm. J. Hamper</u>		DATE SIGNED <u>Mar 29 1955</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>4-1-55</u>		NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>	
LOCATION (City, town, or county) (State) <u>German Hill Rd. Md.</u>		24. FUNERAL DIRECTOR <u>John J. Connolly</u>		ADDRESS <u>12000 Susquehanna Ave</u>	
DATE REC'D BY LOCAL REG. <u>3-30-55</u>		REGISTRAR'S SIGNATURE <u>G. W. [Signature]</u>			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2382

02359
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>Md.</u>		COUNTY	
CITY (If outside corporate limits write RURAL and give nearest town) <u>Town Sparrow Point</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>Baltimore 16 3401-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shipley St. Dept. Berk. Steel Co.</u>				STREET ADDRESS (If rural, give location) <u>2823 Baker St.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH		(Month) (Day) (Year)	
<u>Henry L. Harden</u>				<u>Mar 25</u>		<u>1955</u>	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>Male</u>		<u>W</u>		<u>Married</u>		<u>Aug 2 1904</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Shipper</u>				9b. KIND OF BUSINESS OR INDUSTRY <u>Berk. Steel Co.</u>		9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS. <u>50</u> yrs. Months Days Hours Min.	
10. BIRTHPLACE (State or foreign country): <u>VIRGINIA</u>				11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
12. FATHER'S NAME: <u>HENRY HARDEN</u>				13. MOTHER'S MAIDEN NAME: <u>JENNIE</u>			
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>				15. SOCIAL SECURITY No.: <u>213-07-0912</u>		16. INFORMANT & ADDRESS: <u>ROXIE HARDEN (W) 2823 BAKER ST.</u>	
17. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				18. MEDICAL CERTIFICATION			
Immediate cause (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>			
Antecedent cause(s) (b) <u>420.1</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Coronary occlusion</u>				DUE TO			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		20c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>March 3-15-55-2 PM</u>				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Samuel M. D.</u>				DEPUTY MEDICAL EXAMINER <u>Charles Harper</u> DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>BURIAL</u>				DATE THEREOF <u>3/28/55</u>		NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN CEM.</u>	
DATE REC'D BY LOCAL REG. <u>3-28-55</u>				REGISTRAR'S SIGNATURE <u>W. H. H. H.</u>		24. FUNERAL DIRECTOR <u>Charles Harper</u> ADDRESS <u>512 Cambridge Ave.</u>	

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44 J. P. M. van der Wal

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• THE END •

MARYLAND

2383

02360

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and OR give nearest town) Reisterstown		CITY (If outside corporate limits, write RURAL and give nearest town) Reisterstown	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Glenn Falls Road		STREET ADDRESS (If rural, give location) Glenn Falls Road	
3. NAME OF DECEASED (Type or Print)	(First) George (Middle) W. (Last) Harris	4. DATE OF DEATH (Month) March (Day) 26 (Year) 1955	
5. SEX Male	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single	8. DATE OF BIRTH Nov. 27, 1879
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employed by Balto. County Roads		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday 75 yrs. If under 1 year: Months 7 Days 15 If under 24 hrs. Hours 15 Min.
11. BIRTHPLACE (State or foreign country) Baltimore County		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME George Harris		14. MOTHER'S MAIDEN NAME Alice	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS Bernard Uhler, Reisterstown, Md.			

16. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(a) Immediate cause Generalized Carcinomatosis		7 mo.
(b) Antecedent cause(s) Carcinoma of Stomach		1 yr.
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. 1 schiv. Rectal Abscess		7 mo.
19a. DATE OF OPERATION Aug 54	19b. MAJOR FINDINGS OF OPERATION Carcinoma of Stomach (Reptyloric)	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT, SUICIDE, HOMICIDE (Specify) None	PLACE (Home, farm, factory, street, OF office bldg., etc.) None	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY None	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? None

22. I hereby certify that I attended the deceased from **8-13**, 19**54**, to **3-26**, 19**55**, that I last saw the deceased

alive on **3-15**, 19**55**, and that death occurred at **5:30 P.M.**, from the causes and on the date stated above.

SIGNATURE **A. D. Caples** (Degree or title) **M.D.** ADDRESS **Reisterstown Md.** DATE SIGNED **3-28-55**

23. BURIAL, CREMATION REMOVAL (Specify) Burial	DATE Mar. 29, 1955	NAME OF CEMETERY OR CREMATORY St. Paul	LOCATION (City, town, or county) Baltimore County	(State)
DATE REC'D BY LOCAL REG. 3-29-55	REGISTRAR'S SIGNATURE Mary B. Elise	24. FUNERAL DIRECTOR ADDRESS J.F. Eline & Sons, Reisterstown, Md.		

MARGIN RESERVED FOR BINDING

RECEIVED

APR 1 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2384 7. Film 178 3-17-55 et
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH No.

02361
Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN			
X TOWN Balto.		Life		Baltimore - <i>Md.</i> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS at home				STREET ADDRESS (If rural, give location) Box 626 Bird River Rd.			
3. NAME OF DECEASED: (Type or Print)		(First) RAYMOND		(Middle) W. (or William Raymond) HARRIS		4. DATE OF DEATH (Month) (Day) (Year) March 10, 1955	
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married	8. DATE OF BIRTH: May 10, 1908	9. AGE last birthday: 46 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY: Electrical Contractor		11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Wm. J Harris				14. MOTHER'S MAIDEN NAME: Florence Bevans			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY No.: 219-20-9371		17. INFORMANT & ADDRESS: Mrs. R.W. Harris 626 Bird River Rd. Balto. 20			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
4-20-1 Immediate cause (a) Coronary occlusion with former myocardial infarction DUE TO							
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		R. B. Fisher		M. D.		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): Burial		DATE THEREOF March 13/55		NAME OF CEMETERY OR CREMATORY E. Ebenzer		LOCATION (City, town, or county) (State) Balto., Md.	
DATE REC'D BY LOCAL REG. 3-17-55		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS Lassahn Funeral Home 7401 Belair Rd. 6			

UNITED STATES DEPARTMENT OF COMMERCE
BUREAU OF MARITIME SERVICE
OFFICE OF THE MARITIME COMMISSIONER

MEMORANDUM FOR THE MARITIME COMMISSIONER
SUBJECT: [Illegible]
DATE: [Illegible]
BY: [Illegible]
[The following text is illegible due to extreme fading and bleed-through from the reverse side of the page.]

MARYLAND STATE DEPARTMENT OF HEALTH

02362

2385

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Spanners Pt</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Spanners Pt</u>	
TOWN <u>Spanners Pt</u>		TOWN <u>Spanners Pt</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>707 2d St</u>		STREET ADDRESS (If rural, give location) <u>707 2d St</u>	
3. NAME OF DECEASED (Type or Print) <u>Fredrick</u> (First) <u>Hebron</u> (Middle) <u>Hebron</u> (Last)		4. DATE OF DEATH <u>3-12-1955</u> (Month) (Day) (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>7-1-87</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hebron</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel Mills</u>	9. AGE last birthday <u>67</u> yrs. If under 1 year 1 month 1 day 1 hour 1 min.
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Sam'l Hebron</u>		14. MOTHER'S MAIDEN NAME <u>Catherine</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service)		16. SOCIAL SECURITY No. <u>107 N. Main St Balto 22nd 3/12/55</u>	
17. INFORMANT AND ADDRESS <u>Mary J. Hebron - 707 2d St Spanners Pt</u>			

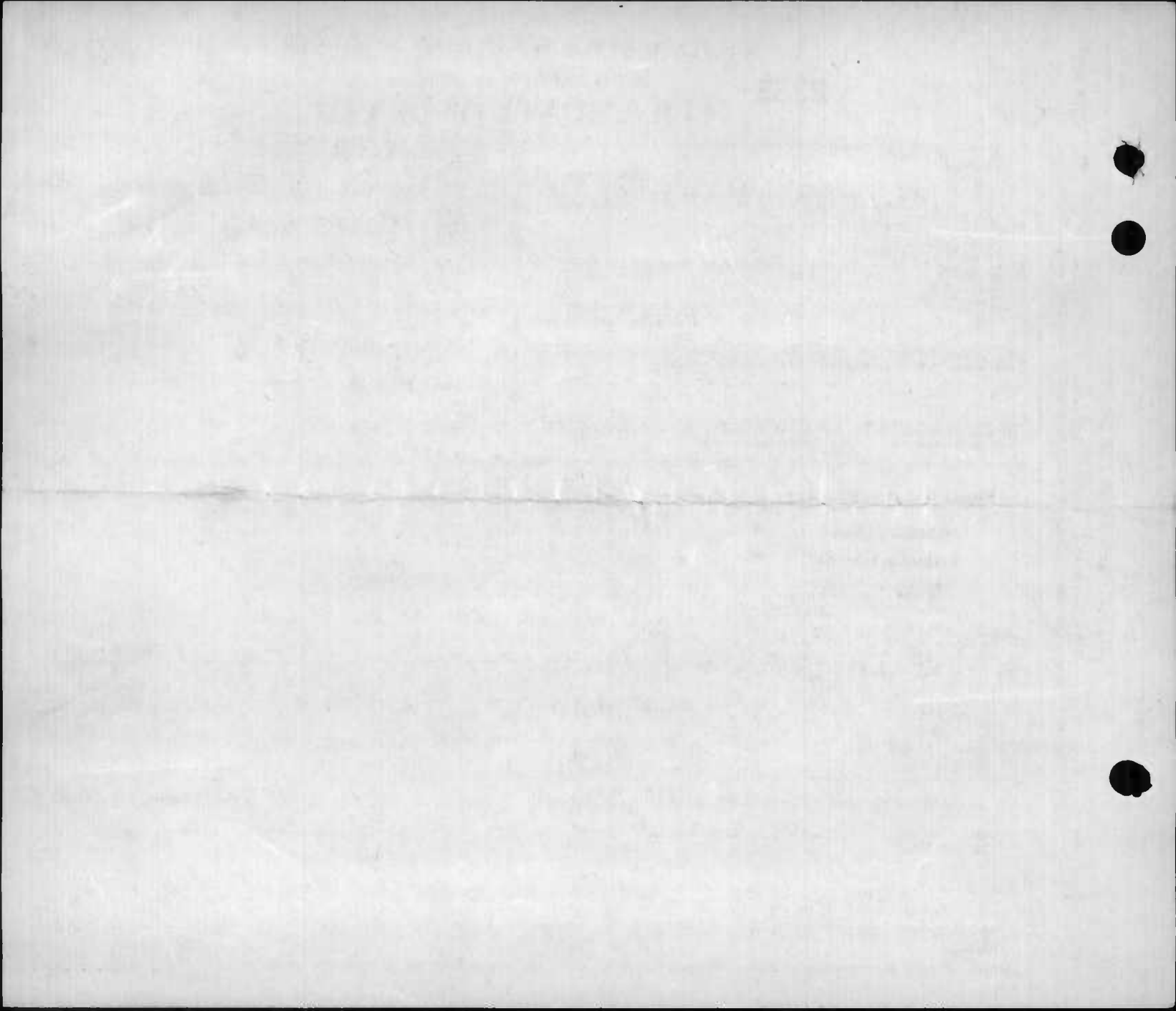
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause <u>492x</u> (a) <u>Virus Pneumonia</u>				<u>10 days</u>	
Antecedent cause(s) <u>Dyspepsia - Arteriosclerosis</u> (b) <u>unknown</u>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>—</u>					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work Not While At work		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>October 10, 1954</u> , to <u>March 12, 1955</u> , that I last saw the deceased alive on <u>March 12, 1955</u> , and that death occurred at <u>4:50 A.M.</u> from the causes and on the date stated above.					
SIGNATURE <u>Dr. Thomas M.D.</u>		ADDRESS <u>107 N. Main St Balto 22nd 3/12/55</u>		DATE SIGNED <u>3/12/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE <u>3-17-55</u>		NAME OF CEMETERY OR CREMATORY <u>Arboretum</u>	
24. FUNERAL DIRECTOR <u>Samuel M. Sullivan Jr</u>		ADDRESS <u>1011 27. Arlington Ave Balto</u>			
DATE REC'D BY LOCAL REG. <u>3-15-55</u>		REGISTRAR'S SIGNATURE <u>AW Fredrick</u>			

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Legation credit?



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2314

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02363

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 9, Film G179 3-28-55 et

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto</u>	
53 CITY (If outside corporate limits, write nearest town) <u>Gray Manor Dundalk</u> OR TOWN <u>Gray Manor</u> LENGTH OF STAY (in this place) <u>3 1/2 yrs</u>		53 CITY (If outside corporate limits, write nearest town) <u>Gray Manor</u> OR TOWN <u>Gray Manor</u>	
100 HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2704 McComas Ave</u>		STREET ADDRESS (If rural, give location) <u>2704 McComas Ave</u>	
3. NAME OF DECEASED (First) <u>Charlotte</u> (Middle) <u>Elizabeth</u> (Last) <u>Herget</u>		4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>15</u> (Year) <u>1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Sept 7. 64</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	9. AGE last birthday <u>90</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Balto Md</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Sottie Becker</u>		1531 W. Balto St.	

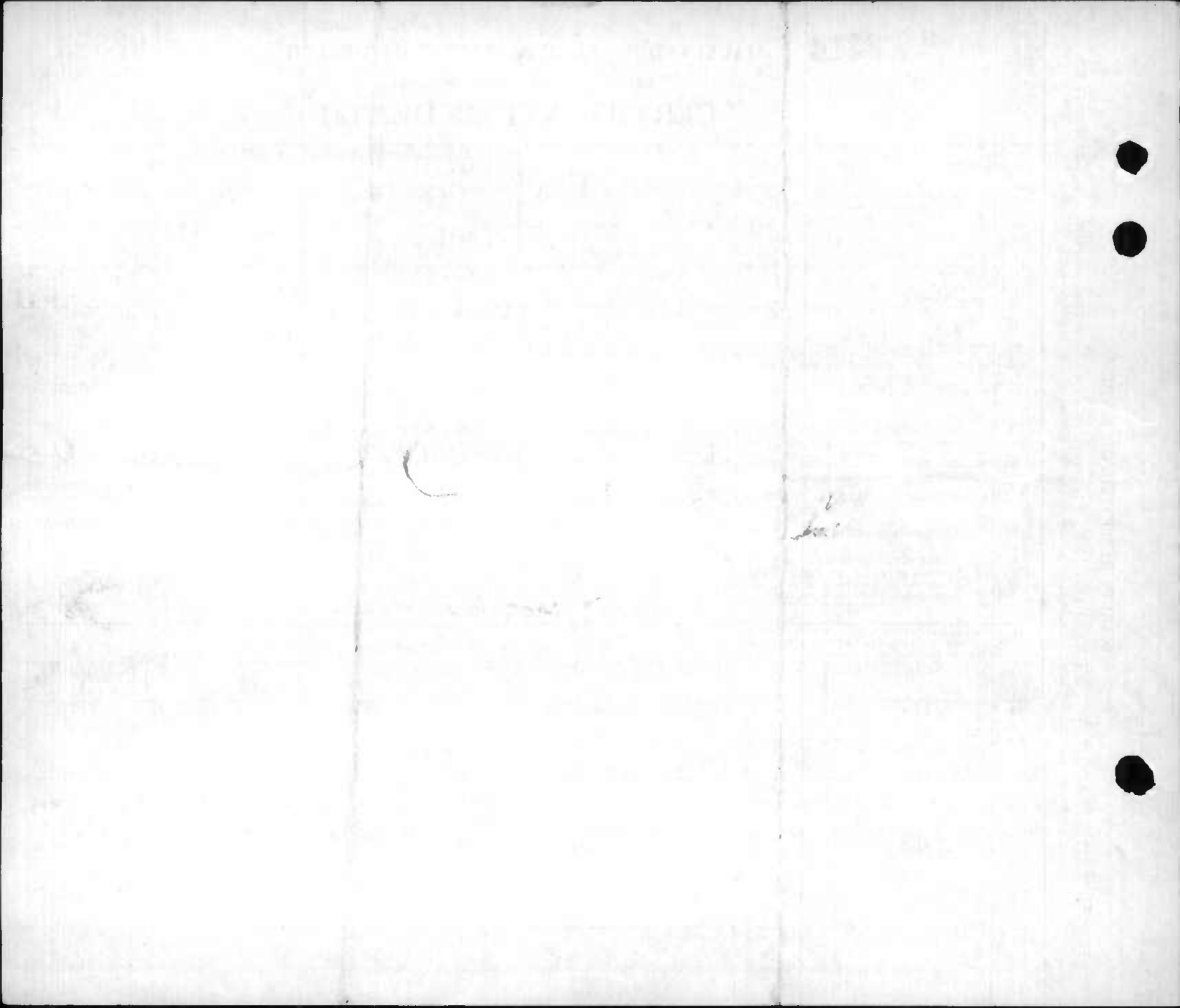
18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>CORONARY Embolism</u>		1 HOUR
Antecedent cause(s) (b) <u>HYPERTENSION</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>ARTERIO-SCLEROSIS - Senile dementia.</u>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Vascular changes</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office hldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1950, to March 15, 1955, that I last saw the deceased alive on March 15, 1955, and that death occurred at 1:50 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

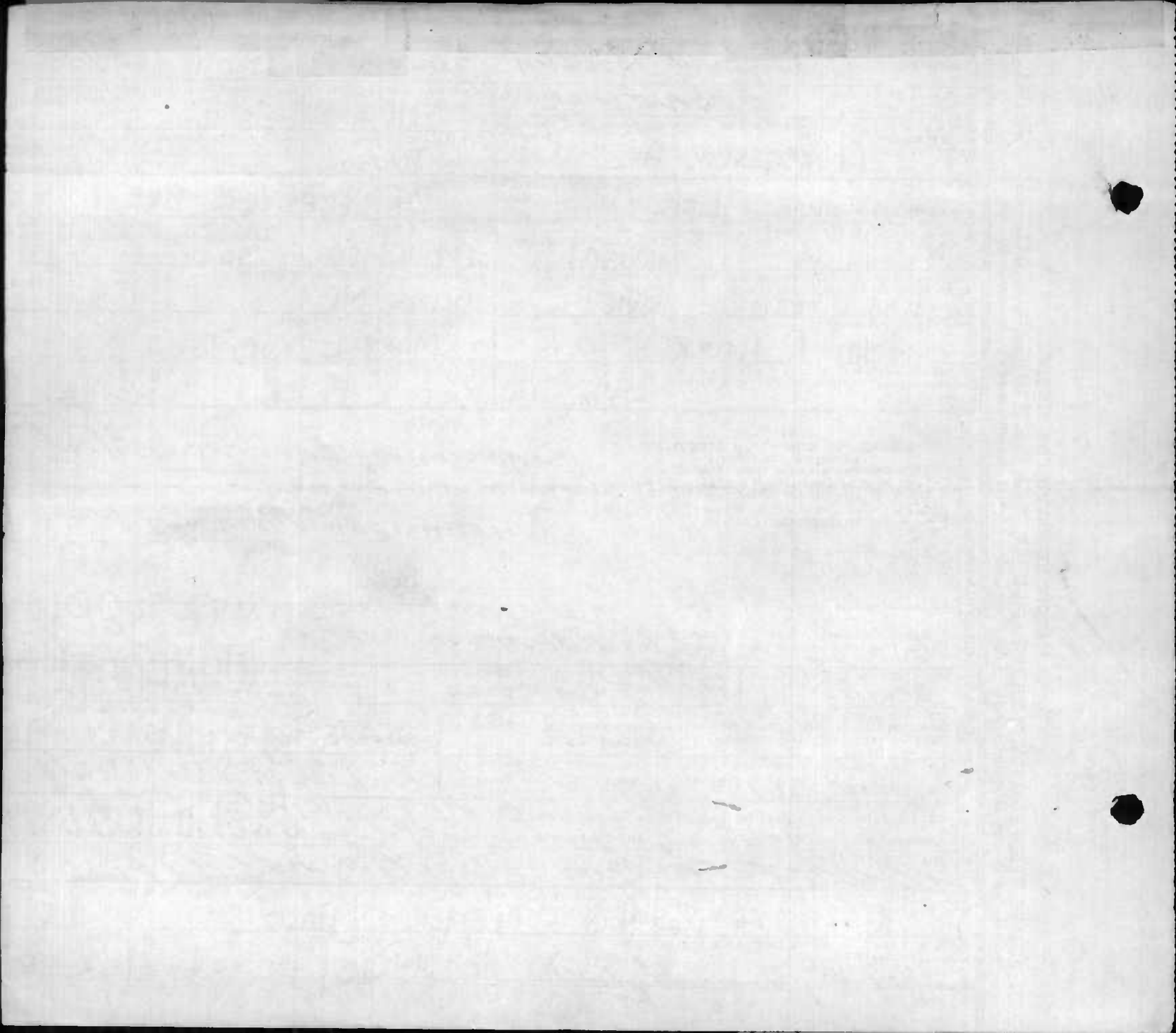
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3/18/55</u>	<u>First United Ch. Cem.</u>	<u>Balto Md</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3-17-55</u>	<u>Dr. A. Federal</u>	<u>Paul Hellmann</u>	<u>6067 Harford Rd</u>	



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BIRTH NO 2236				CERTIFICATE OF DEATH				Registered No 02364 38			
1. NAME OF DECEASED (Type or Print) WILLIAM JOSEPH HOUCK				2. DATE OF DEATH 3/22/55							
3. PLACE OF DEATH: A. Baltimore Co. Maryland BALTIMORE CO				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD COUNTY BALTO.							
B. FULL NAME OF (If not in hospital or institution, give street address or location) HOSPITAL OR INSTITUTE 21 REGESTER AVE.				C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) TOWSON							
c. Length of stay in Baltimore LIFE				O. STREET ADDRESS (If rural, give location) 21 REGESTER AVE.							
5. SEX M		6. COLOR OR RACE W		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) MARRIED		8. DATE OF BIRTH SEPT. 18, 1904		9. AGE (In years last birthday) 50		11 Under 1 Year Months: Days: 11 Under 24 Hours Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PROTESTOR OPERATOR				10B. KIND OF BUSINESS OR INDUSTRY MOVIE				11. BIRTHPLACE (State or foreign country) BALTO. MD.			
13. FATHER'S NAME JOHN R. HOUCK				14. MOTHER'S MAIDEN NAME MARY E. ROBINSON				12. CITIZEN OF WHAT COUNTRY? U.S.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO				16. SOCIAL SECURITY NO. 213-01-2213		17. INFORMANT ANNA K. HOUCK				ADDRESS ABOVE	
18. 196X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) SARCOMA, LEFT FEMUR				CAUSE OF DEATH SARCOMA, LEFT FEMUR				INTERVAL BETWEEN ONSET AND DEATH 3/19/55			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. GENERALIZED METASTASIS				DUE TO GENERALIZED METASTASIS				10/54			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. AMPUTATION LEFT LEG - SARCOMA								3/19/55			
19A. DATE OF OPERATION 3/29/55				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED SARCOMA				IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) BUSINESS				21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? HARFORD THEATRE (BALTIMORE)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY 12 29 1950				21E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21F. HOW DID INJURY OCCUR? Struck leg on metal cabinet			
22. I hereby certify that I attended the deceased from 10/20/54 , 19__, to 3/22/55 , 19__, that I last saw the deceased alive on 3/21/55 , 19__, and that death occurred at 8 P. m., from the causes and on the date stated above.											
23A. SIGNATURE Walter E. Kemp				23B. ADDRESS 4331 Harford Rd				23C. DATE SIGNED 3/22/55			
24A. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 3-26-1955				24C. NAME OF CEMETERY OR CREMATORY HOLY REDEEMER			
24D. LOCATION (City, town, or county) BALTO.				24E. LOCATION (State) MD.							
DATE RECEIVED BY LOCAL REGISTRAR 3-24-55				REGISTRAR'S SIGNATURE A. W. [Signature]				25. FUNERAL DIRECTOR H.W. JENKINS & SONS Co.			
								ADDRESS 4905 YORK RD.			



2387

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>SAME</u>		COUNTY	
CITY (If outside corporate limits, write OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		X	
X TOWN <u>EDGEWATER (19)</u>		<u>13 YRS</u>		STREET ADDRESS <u>#1</u>		(If rural give location) <u>AS</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2628 BRANNON AVE.</u>							
3. NAME OF DECEASED: (First) <u>FLORENCE</u> (Middle) <u>EDNA</u> (Last) <u>HOUTZ</u>				4. DATE OF DEATH: (Month) <u>3</u> (Day) <u>6</u> (Year) <u>19 55</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>DEC. 24, 1888</u>	9. AGE last birthday: <u>66</u> yrs.	IF UNDER 1 YEAR: Months <u>—</u> Days <u>—</u> Hours <u>—</u> Min. <u>—</u>		IF UNDER 24 HRS. <u>—</u>
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired. <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>PENNA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>							
13. FATHER'S NAME: <u>NATHANIEL BECHTEL</u>				14. MOTHER'S MAIDEN NAME: <u>ELIZABETH CULVEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>194-12-6032</u>		17. INFORMANT & ADDRESS: <u>JOHN E. HOUTZ - 2628 BRANNON AVE.</u>			
18. MEDICAL CERTIFICATION				Interval Between Onset And Death			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause <u>420.0</u> (a) <u>acute coronary insufficiency</u>				<u>15 min.</u>			
Antecedent causes (s) <u>Arteriosclerotic Heart Disease</u> (b) <u>—</u>				<u>4 yrs.</u>			
(c) <u>—</u>							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>—</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY: Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		HOMICIDE					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>54</u> , to <u>Mar 6</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Mar 6</u> , 19 <u>55</u> , and that death occurred at <u>9:10 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>James T. Means</u>		(Degree or title) <u>M. D.</u>		ADDRESS <u>520 D. St. Balts. 19 Ind.</u>		DATE SIGNED <u>3/6/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>3-9-55</u>		NAME OF CEMETERY OR CREMATORY <u>LUTHERAN & REFORM</u>		LOCATION (City, town, or county) (State) <u>ORWIN - PENNA.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>March 8-55</u>		REGISTRAR'S SIGNATURE <u>Dawson L. Harbor</u>		24. FUNERAL DIRECTOR <u>Walter Bank Bradley, Wendell, Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

514 C

BUREAU VI 31

MAR 10 1955

RECEIVED

2388

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 TOWN Catonsville		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Baltimore		3701-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 90 Paradise Nursing Home				STREET ADDRESS (If rural give location) 6816 Gough St.			
3. NAME OF DECEASED: (First) EDWARD		(Middle) A.		(Last) HOYT		4. DATE OF DEATH: March 23, 1955	
5. SEX: Male		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married		8. DATE OF BIRTH: Aug. 21, 1891	
9. AGE last birthday: 63 yrs.		10. BIRTHPLACE (State or foreign country): Maryland		11. CITIZEN OF WHAT COUNTRY? U.S.A.		12. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired. Foreman				10b. KIND OF BUSINESS OR INDUSTRY: National Cash Co.		11. BIRTHPLACE (State or foreign country): Maryland	
13. FATHER'S NAME: ? Hoyt				14. MOTHER'S MAIDEN NAME: ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No.				16. SOCIAL SECURITY No.: (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: Mrs. Margaret Haas 6816 Gough St.	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
421.0 Immediate cause (a) Myocardial failure				72 hours			
Antecedent causes (s) (b) Myocardial degeneration				Unknown			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) Arteriosclerotic CVD				Unknown			
11. OTHER SIGNIFICANT CONDITIONS				18 mos.			
Conditions contributing to the death but not related to the disease or condition causing death. (1) Hemiplegia (2) Parkinsonism				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-29, 1954, to 3-23, 1955, that I last saw the deceased alive on 3-23, 1955, and that death occurred at 8:50 P.M., from the causes and on the date stated above.							
SIGNATURE (Degree or title) Stephen Lee Hagness M.D.				ADDRESS Catonsville 28, Md			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		March 26, 1955		Parkwood		Parkville, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
3-26-55		U.E. Harry		Ullrich Funeral Home		4210 Belair Road.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 29 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02367

2389

CERTIFICATE OF DEATH

Reg. Dist. No. *94*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY WIDOMICK	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Fort Howard		LENGTH OF STAY (in this place) 42 Days		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 Veterans Administration Hospital				STREET ADDRESS (If rural give location) 206 Glen Avenue			
3. NAME OF DECEASED: (First) (Middle) (Last) HAROLD S. HUFFINGTON				4. DATE (Month) (Day) (Year) OF DEATH: March 28, 19 55			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married	8. DATE OF BIRTH: March 6, 1896	9. AGE last birthday 59 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10B. KIND OF BUSINESS OR INDUSTRY: Insurance		11. BIRTHPLACE (State or foreign country): Princess Anne, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: Alexander J. Huffington				14. MOTHER'S MAIDEN NAME: Elizabeth Malone			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. 212-03-5308		17. INFORMANT & ADDRESS: Clin.Rec., Vet. Adm. Hosp., Fort Howard, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 163X (A) CEREBRAL HEMORRHAGE, RIGHT, IN METASTASES FROM CARCINOMA, RIGHT LUNG						1 DAY	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Feb. 14, 1955 , to Mar. 28, 1955 , that he died on the 28th day of March , 1955, at 5:20 P. M., from the causes and on the date stated above.							
SIGNATURE William B. VanDeGrift, M. D.				ADDRESS M. D. VAH, Fort Howard, Md. 3-29-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/31/55		NAME OF CEMETERY OR CREMATORY Manokin Cemetery		LOCATION (City, town, or county) (State) Princess Anne, Maryland	
DATE REC'D BY LOCAL REGISTRAR MAR 29 1955		REGISTRAR'S SIGNATURE Arthur L. Fisher		24. FUNERAL DIRECTOR ADDRESS Walter Holloway & Company Salisbury, Maryland			

BUREAU V. S.

APR 1 1955

RECEIVED

2390

CERTIFICATE OF DEATH

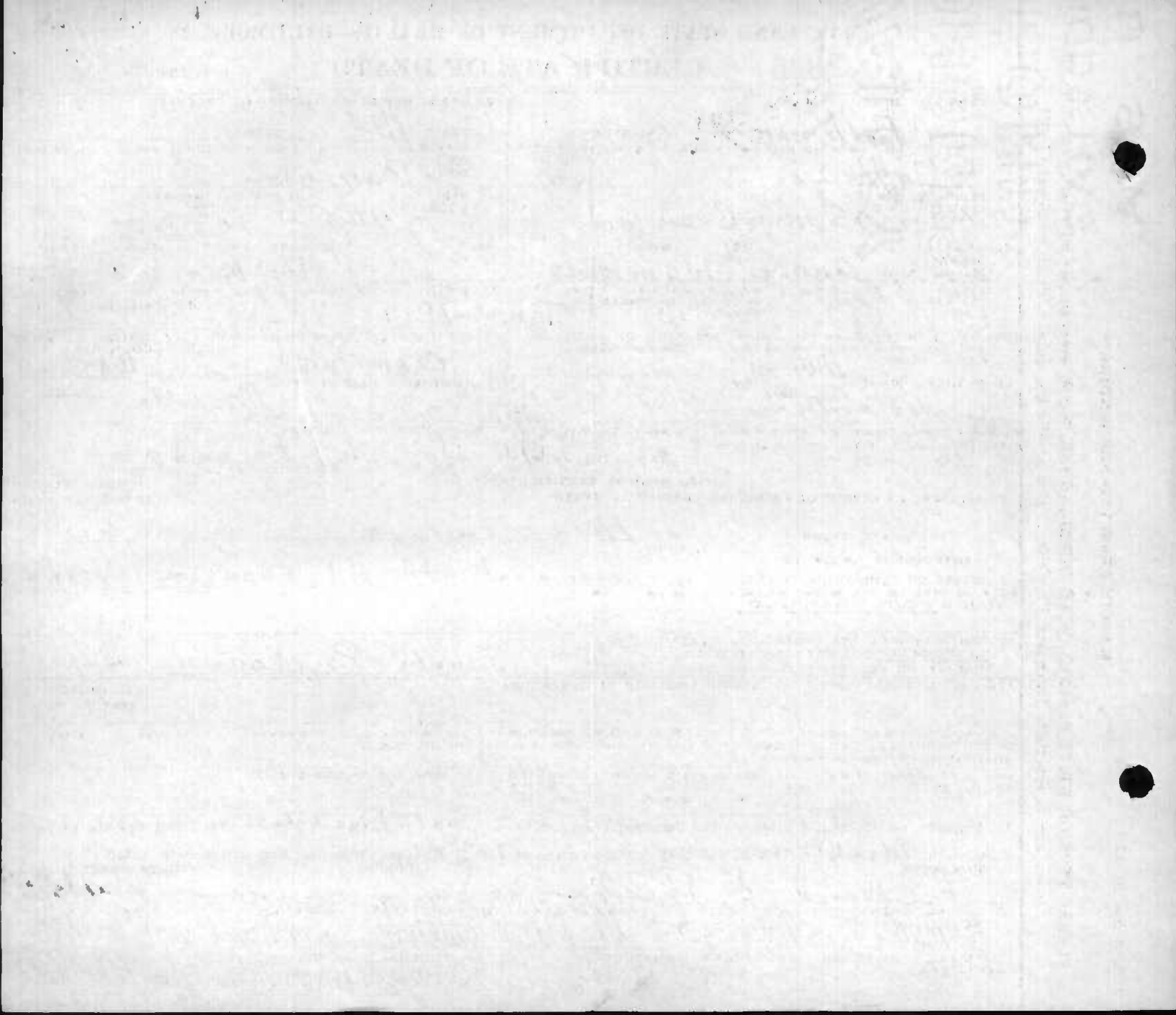
Reg. Dist. No.

30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR and give nearest town				OR TOWN <u>Baltimore</u>			
TOWN <u>Catonsville</u>		<u>4 yrs</u>		STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hosp.</u>				ADDRESS <u>1105 W 37th St</u>			
3. NAME OF DECEASED: (First) <u>Annie M.</u> (Middle) <u>Humbert</u> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar 27 1955</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>W</u>	8. DATE OF BIRTH: <u>Jan. 4 - 1877</u>	9. AGE last birthday: <u>78</u> yrs	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months	Days	Hours	Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>H.W.</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>William Lockingbell</u>				14. MOTHER'S MAIDEN NAME: <u>Maranda</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.: <u>None</u>		17. INFORMANT & ADDRESS: <u>Hospital Records</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>420.0</u>						<u>6 wks</u>	
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<u>1 year</u>	
(A) <u>Heart Failure</u>							
DUE TO							
(B) <u>Arteriosclerotic Ht. Disease</u>							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Senile Psychosis</u>						<u>4 yrs.</u>	
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec 7, 1951</u> , to <u>March 27, 1955</u> , that I last saw the deceased alive on <u>March 27, 1955</u> , and that death occurred at <u>12⁰²</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Frederick E. Phileys</u>				M. D. <u>Spring Grove Hosp</u>		DATE SIGNED <u>3/27/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>March 30 - 1955</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's (Catholic) Silver Run, Carroll Co., Md</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>5-29-55 R. W. Hedrick</u>		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR <u>Surgee Funeral Home</u>		ADDRESS <u>3631 Falls Road</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2391

CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FORT HOWARD</u>		LENGTH OF STAY (in this place) <u>2 DAYS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VETERANS ADMINISTRATION HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>2854 RAYNER AVENUE</u>			
3. NAME OF DECEASED: (Type or Print) <u>SYLVESTER W. HUNTER</u>		(First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH <u>MARCH 4 1955</u>			
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>	8. DATE OF BIRTH: <u>11-7-90</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>HUCKSTER</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>GEORGE HUNTER</u>				14. MOTHER'S MAIDEN NAME: <u>SUSIE COTTMAN</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>YES</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT & ADDRESS: <u>CLIN. REC., VET. ADM. HOSPITAL, FT. HOWARD, MD</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>				APPROX. <u>4</u> MOS.			
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>BRONCHOPNEUMONIA, BILATERAL, BASILAR</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>MARCH 2, 1955</u> , to <u>MARCH 4, 1955</u> , and that death occurred at <u>9:00AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey</u>		ADDRESS <u>VAH, FT. HOWARD, MD</u>		DATE SIGNED <u>3/4/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-8-55</u>		NAME OF CEMETERY OR CREMATORY <u>MOUNT CATHART CEMETERY</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MARYLAND</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-7-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Mrs. Samuel T. Hemsley</u>		ADDRESS <u>578 W. Biddle St., Balto., Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS
COMMONWEALTH OF MASSACHUSETTS
DEPARTMENT OF REVENUE
OFFICE OF THE COMMISSIONER
BOSTON, MASSACHUSETTS
JANUARY 1, 1900
TO THE HONORABLE SENATE
AND THE HONORABLE HOUSE OF REPRESENTATIVES
IN LEGISLATIVE SESSION
AT BOSTON, MASSACHUSETTS
IN RESPONSE TO A RESOLUTION PASSED BY THE SENATE
AND THE HOUSE OF REPRESENTATIVES
JANUARY 1, 1900
RELATIVE TO THE REPORT OF THE COMMISSIONER
OF THE DEPARTMENT OF REVENUE
FOR THE YEAR 1899
AS ORDERED BY THE SENATE
AND THE HOUSE OF REPRESENTATIVES
JANUARY 1, 1900
COMMISSIONER OF THE DEPARTMENT OF REVENUE
BOSTON, MASSACHUSETTS

2392

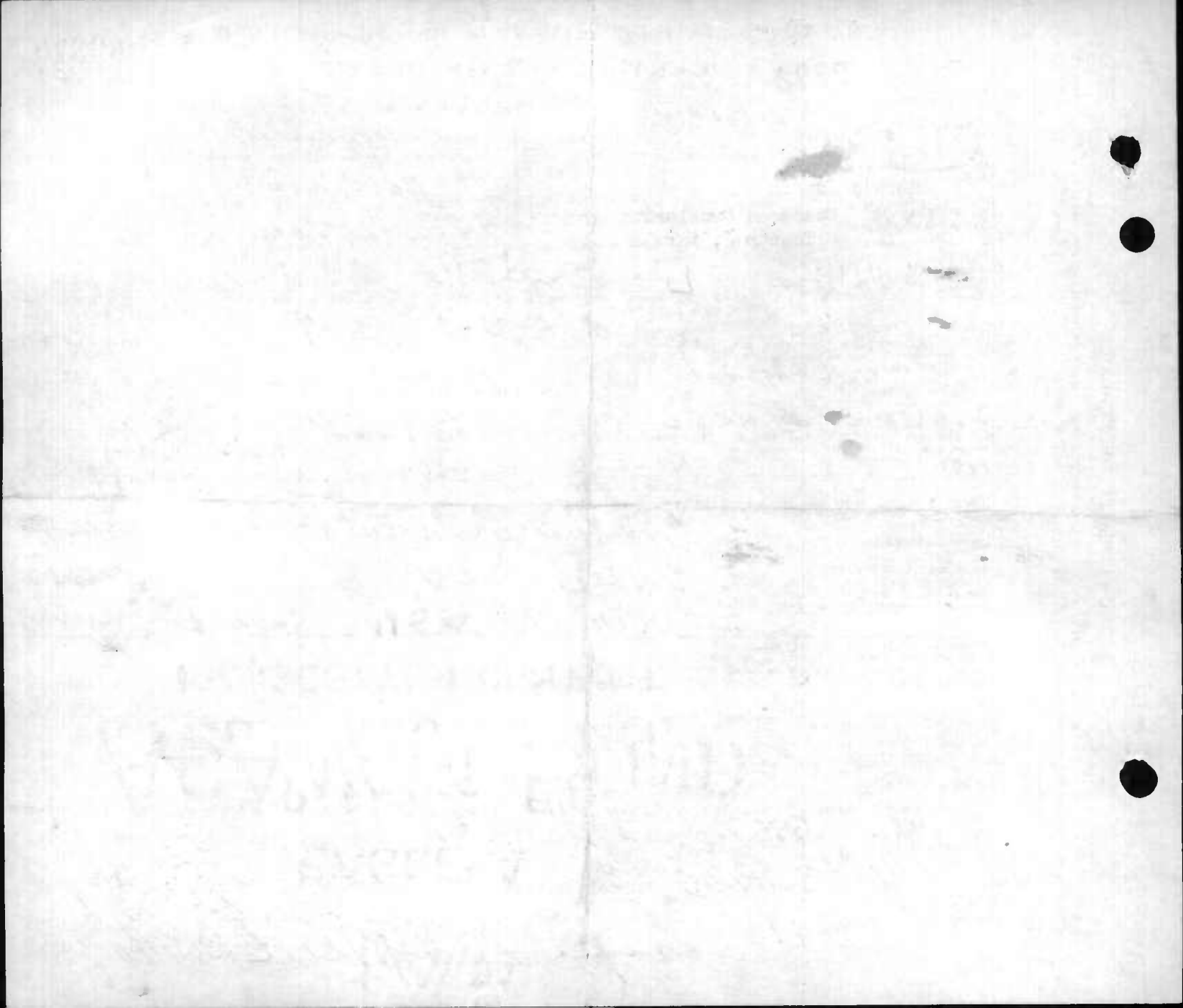
CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH: Eudowood San. Towson 4 COUNTY Baltimore MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MARYLAND COUNTY Balto. CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore 3V01-4 STREET ADDRESS (If rural give location) 4512 Old Frederick Rd.			
3. NAME OF DECEASED: (Type or Print) William (First) L. (Middle) Iardella (Last)				4. DATE OF DEATH: March 4 1955			
5. SEX: MALE		6. COLOR OR RACE: White		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED		8. DATE OF BIRTH: 4-30-87	
9. AGE last birthday: 67 yrs.		10. USUAL OCCUPATION, Give kind of work done during most of working life, even if retired: CIVIL ENGINEER		11. BIRTHPLACE (State or foreign country): MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: WALTER L. IARDALLA				14. MOTHER'S MAIDEN NAME: ANNA LYNCH			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): NO		16. SOCIAL SECURITY No.: NONE		17. INFORMANT & ADDRESS: Personal History Hospital Records, Eudowood Sanatorium			
18. MEDICAL CERTIFICATION							Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 002X Immediate cause (a) Pulmonary Tuberculosis Antecedent causes (s) (b) Peptic Ulcer Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) Arteriosclerosis, general							84+2 24+2 Leuk
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 2/17, 1955, to 3/4, 1955, that I last saw the deceased alive on 3/4, 1955, and that death occurred at 7:00 PM, from the causes and on the date stated above. SIGNATURE Milton B. Kress (Degree or title) ADDRESS Eudowood Sanatorium - Towson 4, Maryland DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (Specify) Burial		DATE THEREOF 3/8/55		NAME OF CEMETERY OR CREMATORY Landon Park Balto Md		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR 3-7-55		REGISTRAR'S SIGNATURE C. W. Hedrick		24. GENERAL DIRECTOR Leland Buck		ADDRESS 305 Bayard	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 9, Film G180 4-11-55 et

2393

CERTIFICATE OF DEATH

Reg. Dist. No. 37

02371

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cockeysville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cockeysville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 York Road</u>		STREET ADDRESS (If rural give location) <u>York Road</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>IRWIN MELVILLE ISAACS</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>March 30, 19 55</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>May 6, 1884</u>
9. AGE last birthday <u>71</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Gardner</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Estate Gardens</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Bradley Isaacs</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Blanche Isaacs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT & ADDRESS: <u>Family Records</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 IMMEDIATE CAUSE		(A) <u>Acute myocardial infarction</u>	
ANTECEDENT CAUSE (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <u>coronary thrombosis</u>	
		DUE TO	
		(C) <u>atherosclerosis</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OR INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan</u> , 19 <u>55</u> , to <u>Mar. 30</u> , 19 <u>55</u> ; that I last saw the deceased alive on <u>Mar. 28</u> , 19 <u>55</u> , and that death occurred at <u>6:50 A.</u> M., from the causes and on the date stated above.			
SIGNATURE <u>James R. Bowden</u>		ADDRESS <u>M. D. Lombard, 1545 Lutherville, Md.</u>	
DATE SIGNED <u>Mar. 30, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 2, 1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>April 1955</u>		REGISTRAR'S SIGNATURE <u>Anna Amistead MacRae</u>	
FUNERAL DIRECTOR <u>John Burns' Sons</u>		ADDRESS <u>Towson, Maryland</u>	

BUREAU V. S.

APR 6 1955

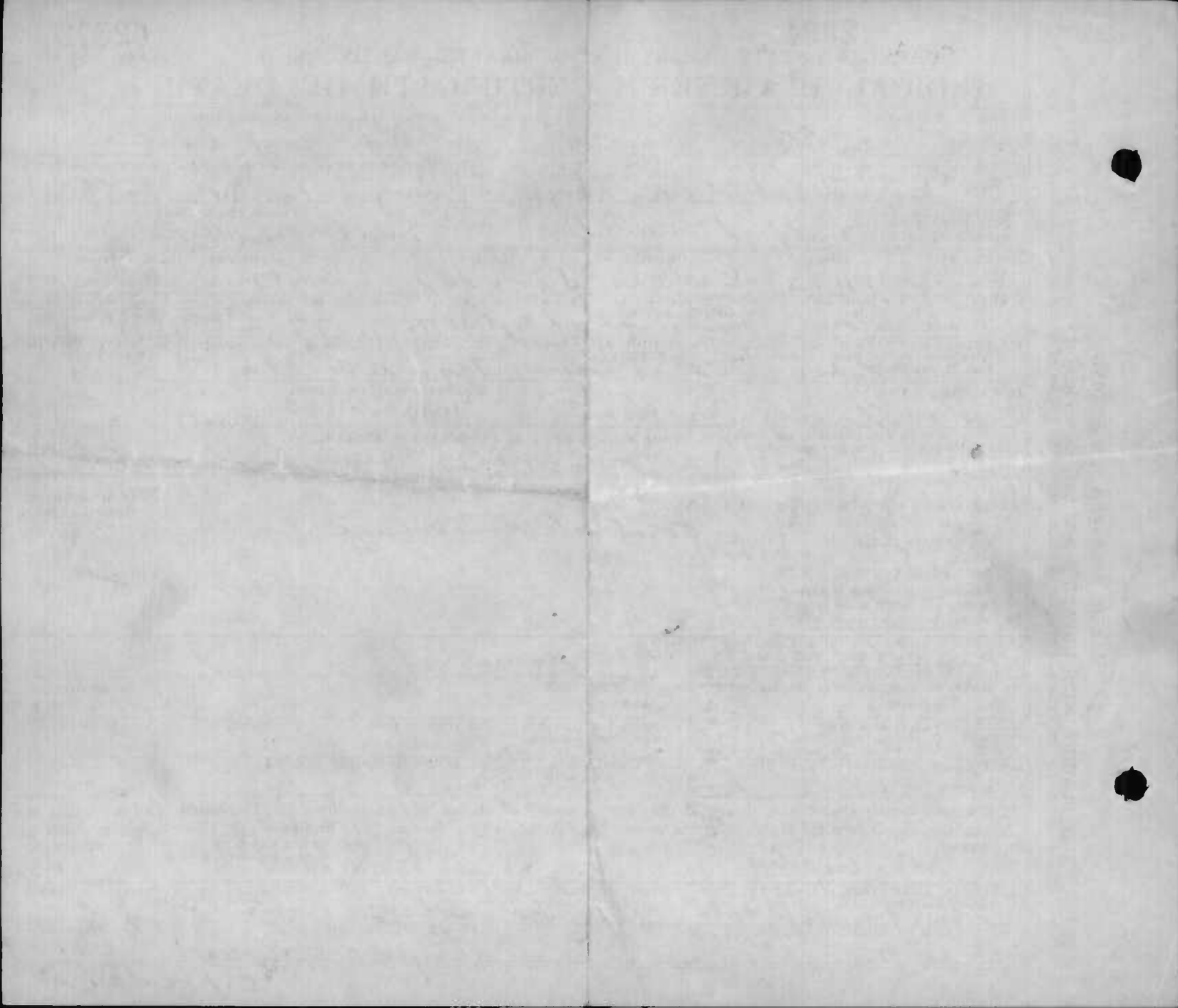
RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2394
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 31

02372
 Reg. Dist.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Wynnum Park Jct. Balto.</u>		<u>2 yrs.</u>		TOWN <u>Wynnum Park Jct. Balto.</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
<u>100 Milford Mill Rd.</u>				<u>Milford Mill Rd.</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print)		<u>THOS. LANDAN JACKSON</u>		<u>Mar 23</u>		<u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>colored</u>	<u>married</u>	<u>Sept 30 '76</u>	<u>77</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Labourer</u>		<u>Stone Quarry</u>		<u>Faquier Co. Va.</u>		<u>W.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Thos. Landan Jackson</u>				<u>Martina Ellen (last)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>No.</u>		<u>none</u>		<u>217 01-0331 Ellen Jane Jackson (wife)</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
331X Immediate cause (a) <u>Cerebral Hemorrhage</u>						<u>7 hrs.</u>	
Antecedent cause(s) (b) <u>none</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY?	
<u>none</u>		<u>none</u>				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
<u>none</u>		<u>none</u>		<u>none</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>none</u>		<u>none</u>		<u>none</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED	
<u>D.D. Caples</u>		<input type="checkbox"/>		<input checked="" type="checkbox"/>		<u>3-23-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/26/55</u>		<u>St. Thomas Cem.</u>		<u>Balto Co, Md</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>March 26 1955</u>		<u>R.W.</u>		<u>Rayner Sanders</u>		<u>217 E. Preston St.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

02373

2315

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dundalk 22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>502 New Pittsburgh Ave.</u>		STREET ADDRESS (If rural, give location) <u>502 New Pittsburgh Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Jannie</u>	(Middle) <u>Young</u>	(Last) <u>James</u>
4. DATE OF DEATH	(Month) <u>March</u>	(Day) <u>18</u>	(Year) <u>1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>February 28, 1909</u>
9. AGE last birthday <u>46 yrs.</u>		10. If under 1 year: Months <u>1</u> Days <u>10</u> Hours <u>10</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machine Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electric Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William Young</u>		14. MOTHER'S MAIDEN NAME <u>Hattie Kelly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217 22 7413</u>	
17. INFORMANT AND ADDRESS <u>Roosevelt James 502 New Pittsburgh Ave #22</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <u>Immediate cause</u> <u>Broncho-pneumonia</u>		<u>2 days</u>
(b) <u>Antecedent cause(s)</u> <u>Carcinoma of Cervix</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>?</u>
(c)		

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from February 12, 1955, to March 18, 1955, that I last saw the deceased alive on March 18, 1955, and that death occurred at 8:30 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

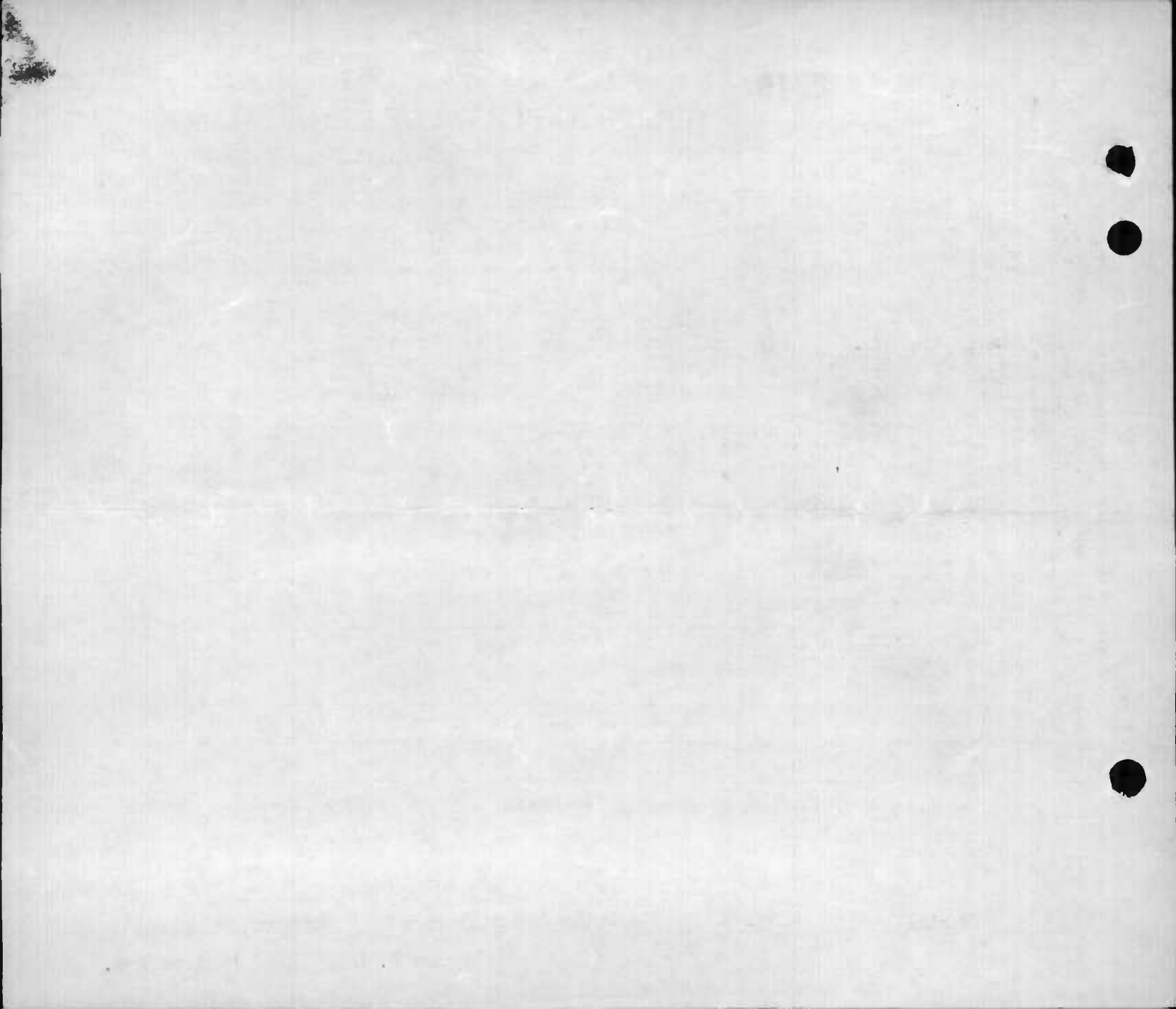
DATE SIGNED

23. BURIAL, CREMATION, REINTERMENT (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3-22-55</u>	<u>Arbutus Memorial Park</u>	<u>Arbutus, Maryland</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3-21-55</u>	<u>W. H. Hedrick</u>	<u>Charles R. Law</u>	<u>802 Madison Ave.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2395

CERTIFICATE OF DEATH

Reg. Dist. No. 36

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Ann Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN Annapolis</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>3 Mile Oak</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>Angeline Jenkins</u>		<u>March 9, 19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>2-1-1871</u>
9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>84</u> yrs.	Months Days	Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housework</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>HOME</u>	11. BIRTHPLACE (State or foreign country): <u>Alabama</u>
13. FATHER'S NAME: <u>Daniel Moore</u>		14. MOTHER'S MAIDEN NAME: <u>Martha Moore</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hosp.</u>
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
<u>422.1</u>			
IMMEDIATE CAUSE (A) <u>Cardiac failure</u>			
ANTECEDENT CAUSE (S) DUE TO <u>Arteriosclerotic c. v. disease</u>			Years
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>9-23-</u> , 19 <u>54</u> , to <u>3-9-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-9-</u> , 19 <u>55</u> , and that death occurred at <u>3:00 P.</u> from the causes and on the date stated above.			
SIGNATURE <u>S. Wachler</u>		ADDRESS <u>Spring Grove State Hospital</u> DATE SIGNED <u>3-9-55</u>	
M. D. <u>Catonsville</u>		LOCATION (City, town, or county) (State) <u>MD.</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>3/11/55</u>	<u>GLEN HAVEN</u>	<u>GLEN BURNIE MD.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>March 11, 1955</u>	<u>Victor E. Harvey</u>	<u>JOHN M. TAYLOR + SONS</u>	<u>Annapolis</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 15 1955

RECEIVED

2396

02375

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 30

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u>		MARYLAND	STATE <u>Maryland</u>		COUNTY <u>Prince George</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>1yr. 1mo. 4day</u>	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Colmar Manor</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>			STREET ADDRESS <u>3605 40th Place</u> (If rural, give location)		
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>John E. Joeckel</u>			4. DATE OF DEATH <u>March 17,</u> 19 <u>55</u>		
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>2-8-1878</u>	9. AGE last birthday: <u>77</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME: <u>George Joeckel</u>			14. MOTHER'S MAIDEN NAME: <u>Barbara Anna</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>	17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>		

18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					
420.1 Immediate cause (a) <u>Coronary thrombosis</u>		DUE TO			
Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u>		DUE TO			
2604 Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Arteriosclerotic heart disease</u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Diabetes Mellitus--Cirrhosis of liver</u>					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town)	(County)	(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Leo M. Kieffer</u>		1010 <u>Leedon</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3-17-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>3/19/55</u>	NAME OF CEMETERY OR CREMATORY <u>St. Lincoln</u>		LOCATION (City, town, or county) (State) <u>Colmar Manor, Md.</u>	
DATE REC'D BY LOCAL REG. <u>3/18/55</u>	REGISTRAR'S SIGNATURE <u>Umanda Downey</u>	24. FUNERAL DIRECTOR <u>F. Gasco's Sons, Hyattsville, Md.</u>		ADDRESS <u>7-21-55</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 22 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 182376 42
 CERTIFICATE OF DEATH

Reg. Dist. No. 181

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Hanford</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Relay, 27</u>	LENGTH OF STAY (in this place) <u>1 year 24 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Holland's Hill</u>	<u>124-2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Relay Hill Hosp. Relay 27, Md</u>		STREET ADDRESS <u>Berryman</u>	(If rural give location)
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>Oscar</u>	(Middle) <u>M</u>	(Last) <u>Johnson</u>	(Month) <u>March</u> (Day) <u>5</u> (Year) <u>1955</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>Jan 31-1873</u>
9. AGE last birthday: <u>82</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Farm</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME: <u>George Johnson</u>		14. MOTHER'S MAIDEN NAME: <u>Katie V. Halloway</u>	
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>—</u>	
17. INFORMANT & ADDRESS: <u>Relay Hill Hosp. Relay Maryland</u>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death
<u>493X</u> Immediate cause (a) <u>Pulmonary Edema</u>			<u>6 hours</u>
Antecedent causes (s) (b) <u>Pneumonia, Rt. Lung</u>			<u>10 days</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertrophic Arthritis, Generalized</u>			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
SUICIDE		(CITY OR TOWN)	
HOMICIDE		(COUNTY)	
(STATE)			
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan 31, 1954</u> , to <u>March 5, 1955</u> , that I last saw the deceased alive on <u>March 5, 1955</u> , and that death occurred at <u>10:50 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>Lewis P. Funky M.D.</u>		DATE SIGNED <u>March 5, 1955</u>	
ADDRESS <u>Relay Hill Hosp.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>March 8-1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Shesute Cemetery</u>		LOCATION (City, town, or county) <u>Berryman Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>March 19-55</u>		REGISTRAR'S SIGNATURE <u>George S.M. Keffer</u>	
24. FUNERAL DIRECTOR <u>John G. Barring Aberdeen Md</u>		ADDRESS <u>—</u>	

MAR 15 1955

RECEIVED

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02377
2397 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH: Towson		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Balto. City
CITY (If outside corporate limits, write RURAL OR and give nearest town) 55 TOWSON	LENGTH OF STAY (in this place) 12 days	CITY (If outside corporate limits, write RURAL and give nearest town) TOWSON Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 13 Sheppard & Enoch Pratt Hosp. Towson 4, Maryland		STREET ADDRESS (If rural give location) 4818 Greenspring Avenue	

3. NAME OF DECEASED: (First) Elsie (Middle) Strouse (Last) Kaufman		4. DATE OF DEATH: (Month) March (Day) 19 (Year) 1955	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow	8. DATE OF BIRTH: Oct. 8, 1882
9. AGE last birthday: 72 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): None		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: Samuel Strouse		14. MOTHER'S MAIDEN NAME: Bertha Samstag	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): No (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: ---	
17. INFORMANT & ADDRESS: Hospital records			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
332X Immediate cause (a) Cerebral thrombosis		4 weeks
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Generalized arteriosclerosis		Unk.
(c)		

11. OTHER SIGNIFICANT CONDITIONS		Chronic brain syndrome associated with cerebral arteriosclerosis, with psychotic reaction.	
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from **March 6, 1955**, to **March 19, 1955**, that I last saw the deceased alive on **March 18, 1955**, and that death occurred at **2:30 a.m.**, from the causes and on the date stated above.

SIGNATURE **M. D. Martin** (Degree or title) ADDRESS **Assistant Medical Supt., Sheppard-Pratt Hospital** DATE SIGNED **3/19/55**

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)
Removal	3-21-55	Wash. Hebrew Congregation Cem	Wash. D.C.
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
Mar. 19, 1955	Mabel C. Gray	David R. Martin	1902 Canton Place

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ADMINISTRATIVE

BUREAU V. S.

MAR 21 1965

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02379
2398 CERTIFICATE OF DEATH

Reg. Dist. No. 45

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rosedale</u>	LENGTH OF STAY (in this place) <u>1 yr</u>	CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rosedale</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1028 Sumter Ave.</u>		STREET ADDRESS (If rural give location) <u>1028 Sumter Ave</u>	

3. NAME OF DECEASED: (Type or Print)		(First)	(Middle)	(Last)	4. DATE OF DEATH:	(Month)	(Day)	(Year)
<u>John George Kipp Sr.</u>		<u>John</u>	<u>George</u>	<u>Kipp Sr.</u>	<u>March 4</u>	<u>4</u>	<u>1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	Months	Days
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>July 30th 1881</u>	<u>73</u> yrs.				

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
<u>floor covering</u>	<u>own business</u>	<u>Balto. Co. Md.</u>	<u>U.S.A.</u>

13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:	
<u>Elias Kipp</u>	<u>Mary Dancy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:
<u>No</u>	<u>212-34-8805</u>	<u>Mrs. John G. Kipp 1028 Sumter Ave</u>

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<u>420.1</u>		
Immediate cause	(a) <u>Coronary Occlusion</u>	<u>Sudden</u>
Antecedent causes (s)	(b) <u>Arteriosclerotic Cardio-vascular disease</u>	<u>2 years</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.	(c)	

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY ?
		Yes <input type="checkbox"/> No <input type="checkbox"/>

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR ?		

22. I hereby certify that I attended the deceased from July 1, 1954, to March 4, 1955, that I last saw the deceased alive on March 4, 1955, and that death occurred at 9 P.M., from the causes and on the date stated above.

SIGNATURE	(Degree or title)	ADDRESS	DATE SIGNED
<u>J. M. Baumgardner MD</u>		<u>Balto 6 Md</u>	<u>3/4/55</u>

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>3/8/55</u>	<u>Oak Lawn</u>	<u>Balto. Co.</u>	<u>Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3/8/55</u>	<u>Edith Hurley</u>	<u>Lassahn Funeral Home</u>	<u>4401 Bz 1 air</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 11 1955

BUREAU V. 3

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02380

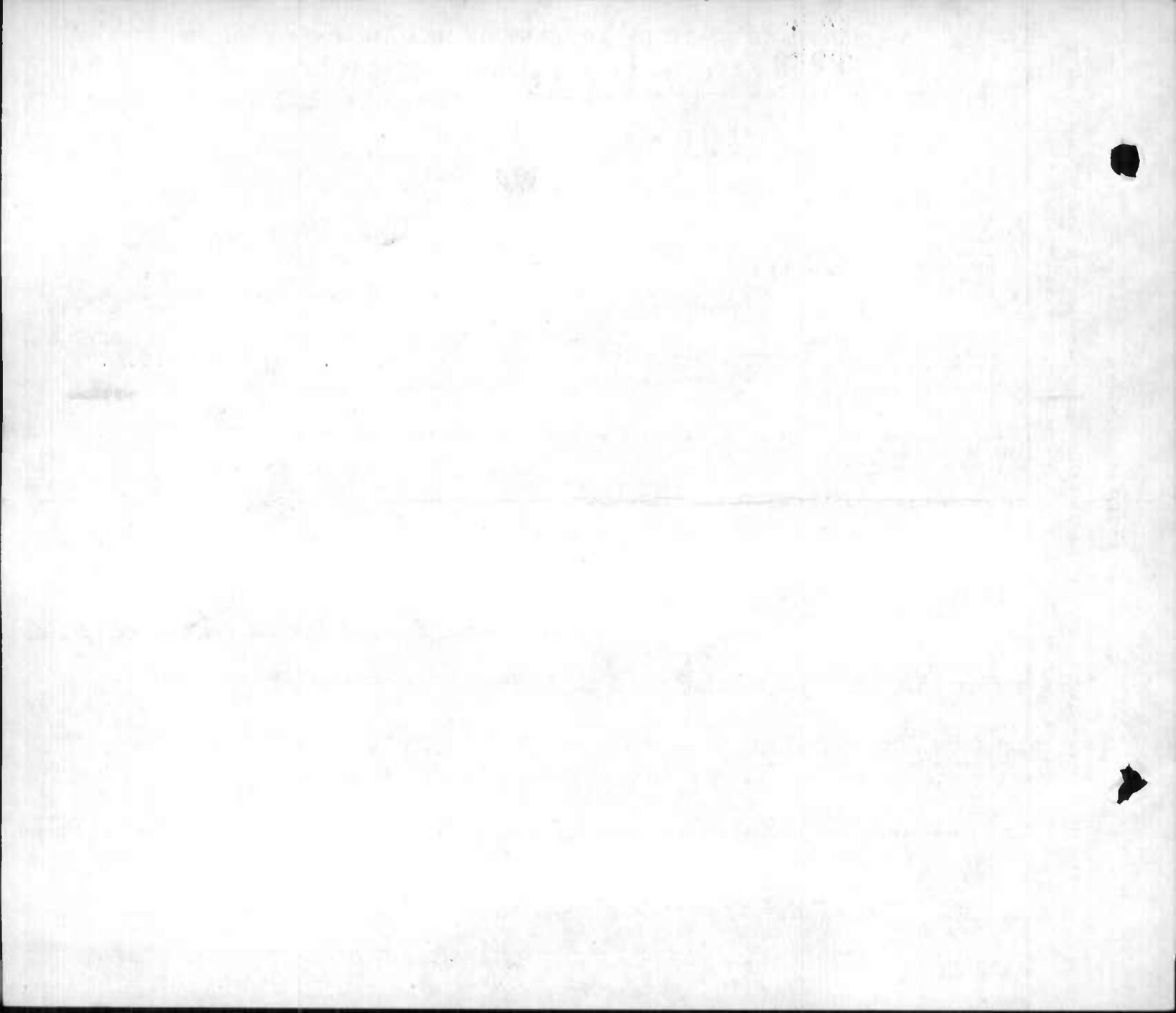
2399

CERTIFICATE OF DEATH

Reg. Dist. No. 38

item 2, Film G178 3-15-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>H/111111/1</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>Rural - Baltimore</u>		<u>1 year</u>		TOWN <u>Rural - Baltimore</u> <u>3 V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Stella Maris Hospice</u> <u>Delaney Valley Road</u>		STREET ADDRESS (If rural give location) <u>4605 York Rd.</u> <u>Stella Maris Hospice</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Cecelia</u> <u>Klug</u>				<u>March 6, 1955</u> <u>19</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH:	9. AGE last birthday yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>Dec. 16, 1881</u>	<u>73</u>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired</u>		<u>Accountancy</u>		<u>Baltimore, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>William J. Klug</u>				<u>Appolonia A. Hupp</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>No</u>		<u>None</u>		<u>Mrs. Bernard A. Grob-5211 Tillbury Way</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						<u>Sudden</u>	
ANTECEDENT CAUSE (S) (B) <u>Hypertensive Cardio Renal</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Vascular Disease</u>						<u>10 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 1953</u> to <u>March 6, 1955</u> , that I last saw the deceased alive on <u>March 5, 1955</u> , and that death occurred at <u>8:20 A</u> M, from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Charles F. O'Donnell</u>		<u>7501 York Rd</u>		<u>3/7/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>March 9, 1955</u>		<u>St. Mary's Cem.</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3/9/55</u>		<u>A. W. Hedrick</u>		<u>John A. Moran-3000 E. Baltimore St.</u>			



2400

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City</u> <u>8901-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>2 weeks</u>		STREET ADDRESS (If rural give location) <u>2827 Rayner Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Katie A. Kohlstead</u>				<u>March 20, 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>Aug. 17, 1869</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>At Home</u>						<u>Baltimore County Maryland</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Tobias Schaar</u>				<u>Caroline Poehlman</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>No</u>						<u>Carl Heinmuller</u>	
18. MEDICAL CERTIFICATION				McDonogh Road McDonogh Md.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
420.9 IMMEDIATE CAUSE				<u>3 months</u>			
ANTECEDENT CAUSE (S)				<u>several years</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Stroke due to cerebral arteriosclerosis</u>							
(B) <u>Arteriosclerosis with cerebral artery disease with hypertension</u>							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>none</u>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>November 19, 1954</u> to <u>March 20, 1955</u> that I last saw the deceased alive on <u>March 14, 1955</u> , and that death occurred at <u>2 P. M.</u> from the causes and on the date stated above.							
SIGNATURE		M. O.		DATE SIGNED			
<u>William Michael</u>		<u>1015 Poplar Street</u>		<u>March 21, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>March 23, 1955</u>		<u>Loudon Park Cemetery</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-22-55</u>		<u>G. W. Hedrick</u>		<u>Ellsworth Armacost</u>		<u>4600 Liberty Heights Ave.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

COMMONWEALTH

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Duplicate *2* MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 *08243*

CERTIFICATE OF DEATH

Reg. Dist. No. *30*

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTIMORE</u>	MARYLAND	STATE <u>MD.</u>	COUNTY <u>BALTIMORE</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>52</i> TOWN <u>Catonsville</u>	LENGTH OF STAY (In this place) <u>1 1/2 yrs</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <i>3401-4</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Wayne Conv. Home 98 Smithwood</u>		STREET ADDRESS (If rural give location) <u>612 S. Ann st.</u> ✓	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JAMES</u> <u>KOMODER</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>March 12</u> <u>19 55</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>July 22 1894</u>
9. AGE last birthday <u>60</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>waterfront</u>	11. BIRTHPLACE (State or foreign country): <u>Poland</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME: <u>ANDREW KOMODER</u>	
14. MOTHER'S MAIDEN NAME: <u>BRILL</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>WWI</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Stella Fak 3630 Chesterfield, Balto. Md.</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
334X IMMEDIATE CAUSE			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) CEREBRAL ATROPHY SECONDARY TO ARTERIOSCLEROSIS			
(B) GENERALIZED ARTERIOSCLEROSIS			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>July 1953</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Trephine negative for surgical brain lesion</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	21D. HOW DID INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
22. I hereby certify that I attended the deceased from <u>Oct. 1953</u> to <u>March 12 1955</u> , that I last saw the deceased alive on <u>March 10, 1955</u> , and that death occurred at <u>3-30P</u> M., from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>M. 1707 Edmondson av. 3-14-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>3-15-55</u>	<u>USN CEM.</u>	<u>Balto. Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3-15-55</u>	<u>V.E. HARRY</u>	<u>MacNABB & SON</u>	<u>CATONSVILLE MD. 28</u>

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

REPORT OF SPECIAL AGENT IN CHARGE
TO DIRECTOR, FBI
FROM [illegible]
DATE [illegible]
SUBJECT [illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a standard report format with sections for 'Facts', 'Analysis', and 'Conclusion'.]

Facts: [illegible]
Analysis: [illegible]
Conclusion: [illegible]

Very truly yours,
[illegible signature]
Special Agent in Charge

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2471 Item 7, Film G178 3-15-55 et
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 02382

Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY BALTIMORE	MARYLAND	STATE Md.	COUNTY Balto.
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Cockeysville	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Parkton	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) JOSEPH	(Middle) PETER	(Last) KOZLOWSKI	(Month) 3 (Day) 5 (Year) 1955
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single	8. DATE OF BIRTH: Apr. 15, 1931
9. AGE last birthday: 23 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): window cleaner		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Charles Kozlowski		14. MOTHER'S MAIDEN NAME: Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: Cockeysville Police			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:			INTERVAL BETWEEN ONSET AND DEATH
871.0 Immediate cause (a) Barbiturate poisoning DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY home)	21c. (City or town) Parkton (County) Baltimore (State) Md.	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY March 5, 1955 M.	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? Ingested barbiturate	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE Paul F. Grier		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 3-5-55 DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM.	
23. BURIAL, CREMATION, REMOVAL (Specify): Removal	DATE THEREOF 3-5-55	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State) Wilmington, De.
DATE REC'D BY LOCAL REG. MAR 7 - 1955	REGISTRAR'S SIGNATURE Paul F. Grier	24. FUNERAL DIRECTOR R. L. Kaczorowski-2525 Fleet St. ADDRESS	

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION & WELFARE
MEDICAL INVESTIGATION OF CHOLERA

Form with multiple horizontal lines for text entry, including fields for patient information, symptoms, and medical history.

BUREAU V. 2

MAR 10 1955

RECEIVED

UNITED STATES DEPARTMENT OF HEALTH, EDUCATION & WELFARE
MEDICAL INVESTIGATION OF CHOLERA

2492

CERTIFICATE OF DEATH

Reg. Dist. No. 37.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Md.</i>		COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Cockeysville</i>		4 yrs.		OR TOWN <i>Cockeysville</i> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Paper Mill Rd.</i>				STREET ADDRESS <i>Paper Mill Rd.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>Charles Robert KRUGER SR.</i>				OF DEATH: <i>MAR. 4</i> (4) 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<i>M</i>	<i>W</i>	<i>Married</i>	<i>8 Dec 1896</i>	<i>58</i> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
		<i>Florist</i>		<i>Woodlawn, Md.</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>August KRUGER</i>				<i>Wilhelmina LEARS</i>			
15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<i>Daughter. (same)</i>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
193X IMMEDIATE CAUSE (A) DUE TO <i>Epileptiform Seizures</i>		<i>6 Mos.</i>
ANTECEDENT CAUSE (S) (B) DUE TO <i>Intracranial Neoplasm. (type undiagnosed)</i>		<i>6 mos.</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?
---	---	----------------------------

22. I hereby certify that I attended the deceased from *Aug.*, 1954, to *4 MAR.*, 1955, that I last saw the deceased alive on *15 Feb.*, 1955, and that death occurred at *9:40 PM*, from the causes and on the date stated above.

SIGNATURE <i>Thomas A. E. Moulton</i>	ADDRESS <i>Cockeysville, Md.</i>	DATE SIGNED <i>4 Mar '55</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	DATE THEREOF <i>MAR. 8, 1955</i>	NAME OF CEMETERY OR CREMATORY <i>CATHEDRAL BALTO MD</i>
DATE REC'D BY LOCAL REGISTRAR <i>14 March 1955</i>	REGISTRAR'S SIGNATURE <i>Ann Armitstead MacRae</i>	24. FUNERAL DIRECTOR <i>MACNABB & SON</i>

MARGIN RESERVED FOR BINDING

1153
p 05 d

RECEIVED

MAR 16 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

243

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

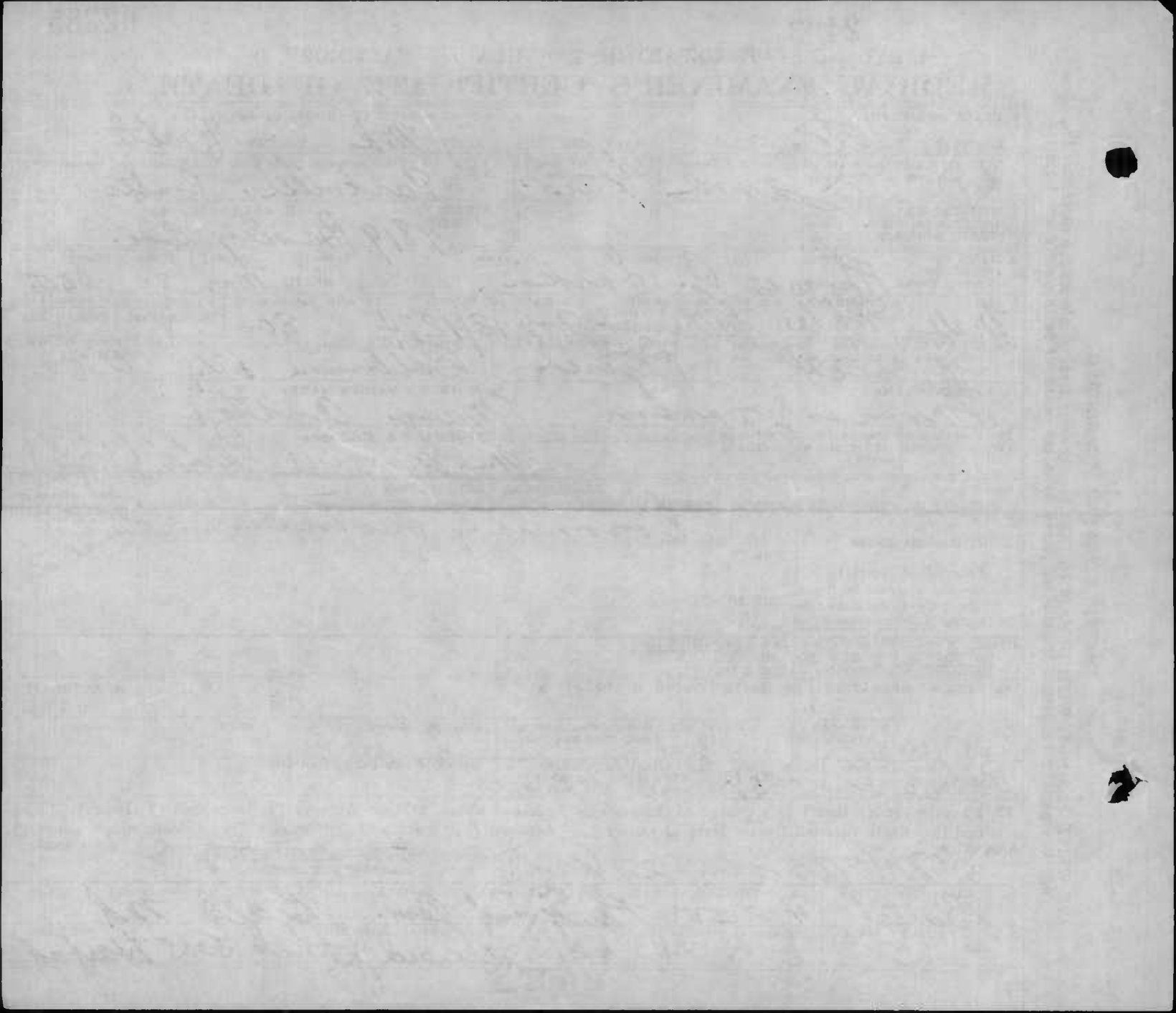
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02385

Reg. Dist. 38

No.

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>same</u> TOWN <u>same</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Parkville, Balto.</u> STREET ADDRESS (If rural give location) <u>4819 Bagley Ave.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Thomas J. Parkin</u> (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 30 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>Nov 18/1874</u>	
9. AGE last birthday: <u>80</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Retired</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore City</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Thomas J. Parkin</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Ashton</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mrs. Margaret Parkin (Wife)</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420.1</u> Immediate cause (a)..... <u>Coronary occlusion.</u> DUE TO Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c).....							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>		21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.					
21a. TIME (Month) (Day) (Year) (Hour) <u>Dec 3 30 55 3 P.M.</u>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		21d. HOW DID INJURY OCCUR?	
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>Wm. J. Parkin M.D.</u>		DATE SIGNED <u>4-2-55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>4-2-55</u>		NAME OF CEMETERY OR CREMATORY: <u>Parkwood Cem.</u>		LOCATION (City, town, or county) (State): <u>Balto MD</u>	
DATE REC'D BY LOCAL REG. <u>3/31/55</u>		REGISTRAR'S SIGNATURE: <u>AWH</u>		24. FUNERAL DIRECTOR: <u>Ronald J. Ruck</u>		ADDRESS: <u>5305 Waverly</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02386

2424 CERTIFICATE OF DEATH

Reg. Dist. No. 30

Item 9, Film 6179 4-5-55 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Pa.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 TOWN Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN East Berlin</u>	<u>75x-3</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Ridgeway Manor 5743 Edmondson Ave.</u>		STREET ADDRESS (If rural give location) <u>--</u>	✓
3. NAME OF DECEASED: (First) (Middle) (Last) <u>AMANDA L. LAU</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>March 28 19 55</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Mar. 5, 1869</u>
9. AGE last birthday: <u>86</u> yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife (rtd)</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>	
11. BIRTHPLACE (State or foreign country): <u>Penna.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Joseph Leib</u>		14. MOTHER'S MAIDEN NAME: <u>Susan Sewers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT & ADDRESS: <u>Mr. Joseph L. Lau-628 Longview Drive 28</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>PULMONARY EDEMA</u>			
ANTECEDENT CAUSE (B) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <u>SENILE ARTERIOSCLEROSIS</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>April</u> , 195 <u>4</u> , to <u>MARCH 1955</u> , that I last saw the deceased alive on <u>Mar 28, 1955</u> , and that death occurred at <u>11:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>P. V. Souk</u>		DATE SIGNED <u>3-29-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>3/31/55</u>	
NAME OF CEMETERY OR CREMATORY <u>East Berlin Union Cem.</u>		LOCATION (City, town, or county) <u>East Berlin, Pa.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-30-55</u>		REGISTRAR'S SIGNATURE <u>E. W. Hedrick</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Tiekner & Sons - Balt'more</u>		ADDRESS	

COLONY OF CEMENT DE Y.

YOUNG L. V. 1304

BYCE Y.

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH- COUNTY Baltimore		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE Md.		COUNTY Balto.	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glenarm		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Glenarm			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Belair Road				STREET ADDRESS Belair Road		(If rural, give location)	
3. NAME OF DECEASED (First) (Type or Print) M. MAMIE LAUBACH		(Middle)		(Last)		4. DATE (Month) (Day) (Year) OF DEATH March 4th 1955	
5. SEX female	6. COLOR OR RACE white	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) married	8. DATE OF BIRTH Sept. 6, 1883	9. AGE last birthday 71 yrs.	If under 1 year Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) Balto. Co., Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME * * * * * Seibert				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none		17. INFORMANT AND ADDRESS Mrs. James Girvin, Belair Rd., Glenarm P.O.			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
260X Immediate cause	(a) Congestive Heart Failure	48 hrs.	
Antecedent cause(s)	(b) Diabetes Mellitus	6 yrs.	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c) Hypertensive Cardiovascular Disease	6 yrs?	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?		Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?	
OF INJURY	While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		

22. I hereby certify that I attended the deceased from 4/21, 1949, to 3/4, 1955, that I last saw the deceased alive on 3/4, 1955, and that death occurred at 9:25 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REG 1743

REGISTRAR SIGNATURE

24 FUNERAL DIRECTOR

ADDRESS

REG 5753

1. 1/2 1/2 1/2 1/2 1/2

Franklin

7401 Belair Rd.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAR 9 1955

BUREAU V. S.

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02388

2496

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
X TOWN <u>Cockeysville (Rural)</u>	<u>3 yrs.</u>	OR TOWN <u>Cockeysville (Rural)</u> X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural give location)		
<u>00 Western Run Rd.</u>	<u>Western Run Rd.</u>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(Type or Print)	(First) (Middle) (Last)	OF DEATH: <u>3 - 25</u> 19 <u>55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>6-26-1868</u>
9. AGE last birthday <u>86</u> yrs.		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>farmowner</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>farm</u>	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
13. FATHER'S NAME: <u>Henry Leaf</u>		14. MOTHER'S MAIDEN NAME: <u>Johanna Myers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. _____	
17. INFORMANT & ADDRESS: <u>Mrs. Margaret E. Leaf, Cockeysville, Md.</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
181X IMMEDIATE CAUSE		(A) <u>Carcinoma of bladder</u> <u>1 yr</u>	
ANTECEDENT CAUSE (S)		(B) <u>nephritis - glomerular</u> <u>year</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C) <u>Hypertension & arteriosclerosis</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		<u>general</u>	
19A. DATE OF OPERATION: <u>✓</u>		19B. MAJOR FINDINGS OF OPERATION: <u>✓</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>3-25-55</u> 19 <u>55</u> , to <u>3-25</u> 19 <u>55</u> , that I last saw the deceased alive on <u>3-25-55</u> 19 <u>55</u> , and that death occurred at <u>3:30</u> P. M., from the causes and on the date stated above.			
SIGNATURE <u>Ann G. Saffell</u>		ADDRESS <u>Reisterstown Md.</u> DATE SIGNED <u>3-26-55</u>	
M. D. <u>Ann G. Saffell</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-28-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Grace Methodist</u>		LOCATION (City, town, or county) (State) <u>Cockeysville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>29 March 1955</u>		REGISTRAR'S SIGNATURE <u>Ann G. Saffell</u>	
24. FUNERAL DIRECTOR <u>Brooks Funeral Service, Sparks, Md.</u>		ADDRESS <u>J. Scott Brooks</u>	

RECEIVED

MAR 31 1955

BUREAU V. S.

2407

CERTIFICATE OF DEATH

02389

Reg. Dist. No.

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>55</u> TOWN <u>Rural: Towson</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>01</u> <u>Eudowood Sanatorium</u> <u>Towson 4, Maryland</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>md.</u> COUNTY <u>Balto 10</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Balto 10 ind.</u> <u>3401.4</u> STREET ADDRESS (If rural give location) <u>402 Woodlawn Rd</u> ✓			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>Friederick W. LEGG</u>			4. DATE OF DEATH: (Month) (Day) (Year) <u>March 23 19 55</u>				
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>April 7 1881</u>	9. AGE last birthday: <u>73</u> yrs.	10. IF UNDER 1 YEAR: Months Days Hours Min.		
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>Ranker</u>			10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Balto. Md</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME: <u>EDGAR K. LEGG</u>			14. MOTHER'S MAIDEN NAME: <u>Ellen Trill</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u> (If Yes, give war or dates of service) <u>WORLD WAR</u>		16. SOCIAL SECURITY No.: <u>25-05-0363</u>	17. INFORMANT & ADDRESS: <u>DECEASED.</u>				

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>002X</u> Immediate cause (a) <u>Pulmonary Tuberculosis</u> DUE TO Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>none</u> DUE TO (c)		<u>5 yrs.</u>

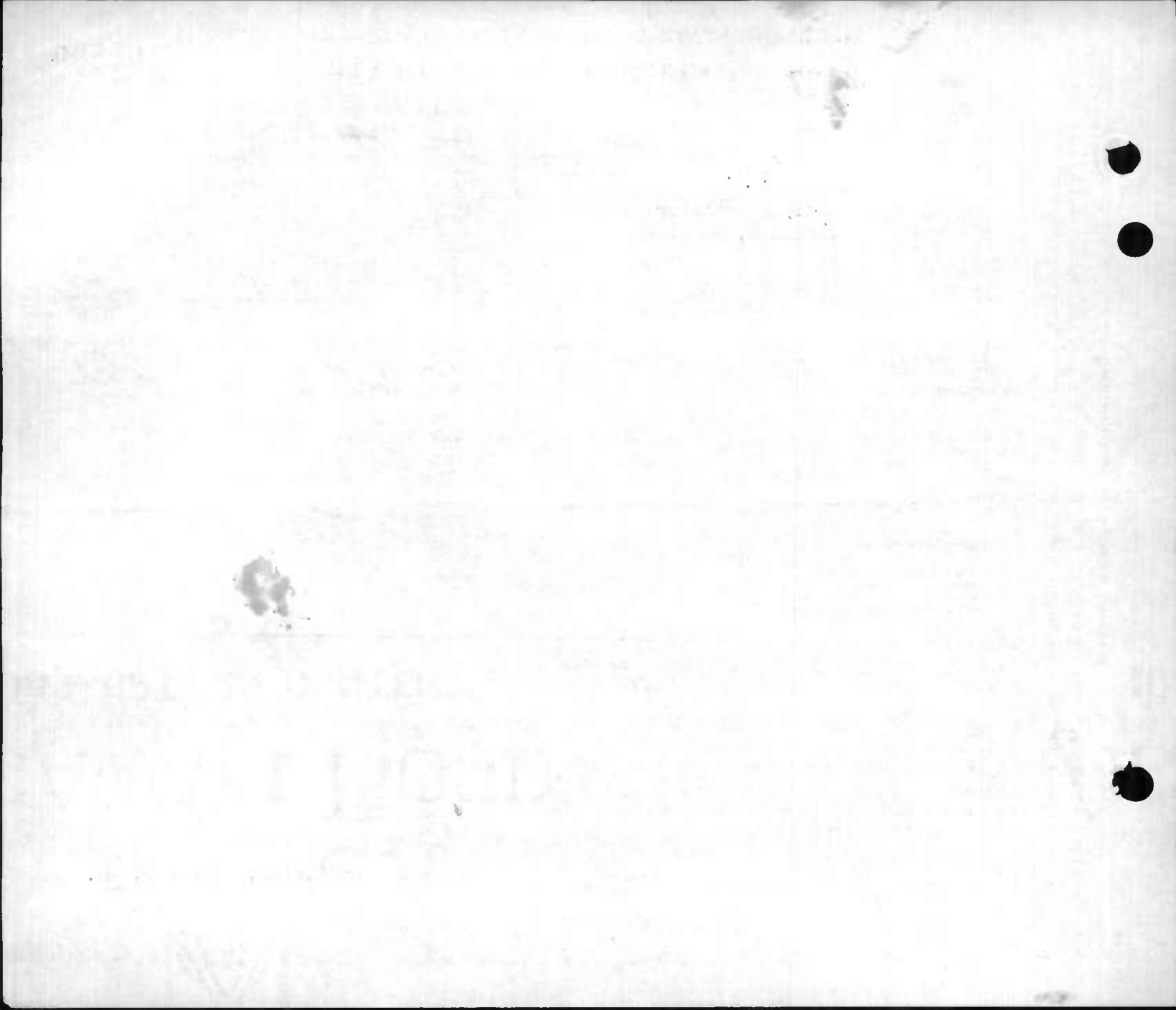
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 11, 1955, to March 23, 1955, that I last saw the deceased alive on March 22, 1955, and that death occurred at 2.23 A.M., from the causes and on the date stated above.

SIGNATURE Milton B. Kress (Degree or title) ADDRESS Eudowood Sanatorium, Towson 4, Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>3/25/55</u>	<u>Dundalk</u>	<u>Pikesville Md</u>	
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3-24-55</u>	<u>R. L. Hedrick</u>	<u>9140 York Rd</u>	<u>Balto</u>	

MARGIN RESERVED FOR BINDING



2478

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3: film G177 3-16-55 CERTIFICATE OF DEATH

Reg. Dist. No.

02390

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD</u> — COUNTY <u>—</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (If this place) <u>38 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove</u>				STREET ADDRESS (If rural give location) <u>1715 Eutaw Pl.</u>		<u>3101-4</u>	
3. NAME OF DECEASED (Type or Print) <u>HARVEY (First) Brooke (Middle) Levening (Last)</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>3</u> <u>3</u> <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>3/29/1879</u>	9. AGE last birthday: <u>75</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Artist</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>	11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Wm Levening</u>				14. MOTHER'S MAIDEN NAME: <u>Cassie Brooke</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT & ADDRESS: <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Pneumonia (Not typed)</u>						<u>4 days</u>	
ANTECEDENT CAUSE (B) <u>Senility</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>							
19A. DATE OF OPERATION: <u>—</u>		19B. MAJOR FINDINGS OF OPERATION: <u>—</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office, bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>—</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>—</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>			
22. I hereby certify that I attended the deceased from <u>1/25/55</u> , 19 <u>55</u> , to <u>3/3/55</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/3/55</u> , 19 <u>55</u> , and that death occurred at <u>8:30 P</u> M, from the causes and on the date stated above							
SIGNATURE <u>Charles Ward M.D.</u>		M.D. <u>Spring Grove Hosp.</u>		DATE SIGNED <u>3/3/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar 16/55</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge</u>		LOCATION (City, town, or county) (State) <u>Pikesville Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE <u>—</u>		24. FUNERAL DIRECTOR <u>Stewart Monro</u>		ADDRESS <u>Balto. Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02391
2409 CERTIFICATE OF DEATH Reg. Dist. No. 37

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Md</i>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town): TOWN <i>Cockeysville</i>	LENGTH OF STAY (in this place) <i>1 1/2 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>	<i>3V01-4</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>90 Macovic Home Cockeysville</i>		STREET ADDRESS (If rural give location) <i>4212 Penhurst Ave</i>	
3. NAME OF DECEASED: (Type or Print) <i>Emma Tolle Lewis</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>Mar. 5 1955</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <i>Aug. 14, 1870</i>
		9. AGE last birthday: <i>84</i> yrs.	IF UNDER 1 YEAR: Months <i>8</i> Days <i>-</i> Hours <i>-</i> Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Own home</i>	11. BIRTHPLACE (State or foreign country): <i>Baltimore</i>
13. FATHER'S NAME: <i>Henry Tolle</i>		14. MOTHER'S MAIDEN NAME: <i>Emma Overlin</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <i>A 213-34-0972</i>	17. INFORMANT & ADDRESS: <i>Laura M Schroeder</i>

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <i>Arterio Sclerosis</i>		<i>long</i>
ANTECEDENT CAUSE (B) <i>Cardio Vascular Disease</i>		<i>1 1/2 yrs</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *Nov 4*, 1953, to *Mar.*, 1955 that I last saw the deceased alive on *Mar 4*, 1955, and that death occurred at *7:24* A.M. from the causes and on the date stated above.

SIGNATURE *Walter T. Lewis* ADDRESS *Cockeysville Md* DATE SIGNED *3/5/55*

M. D. *Cockeysville Md*

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	<i>3/8/55</i>	<i>Woodlawn</i>	<i>Baltimore Md</i>

DATE REC'D BY LOCAL REGISTRAR *3/3/55* REGISTRAR'S SIGNATURE *Laura M. Schroeder* 24. FUNERAL DIRECTOR'S ADDRESS *St. Paul & Preston St*

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 8 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

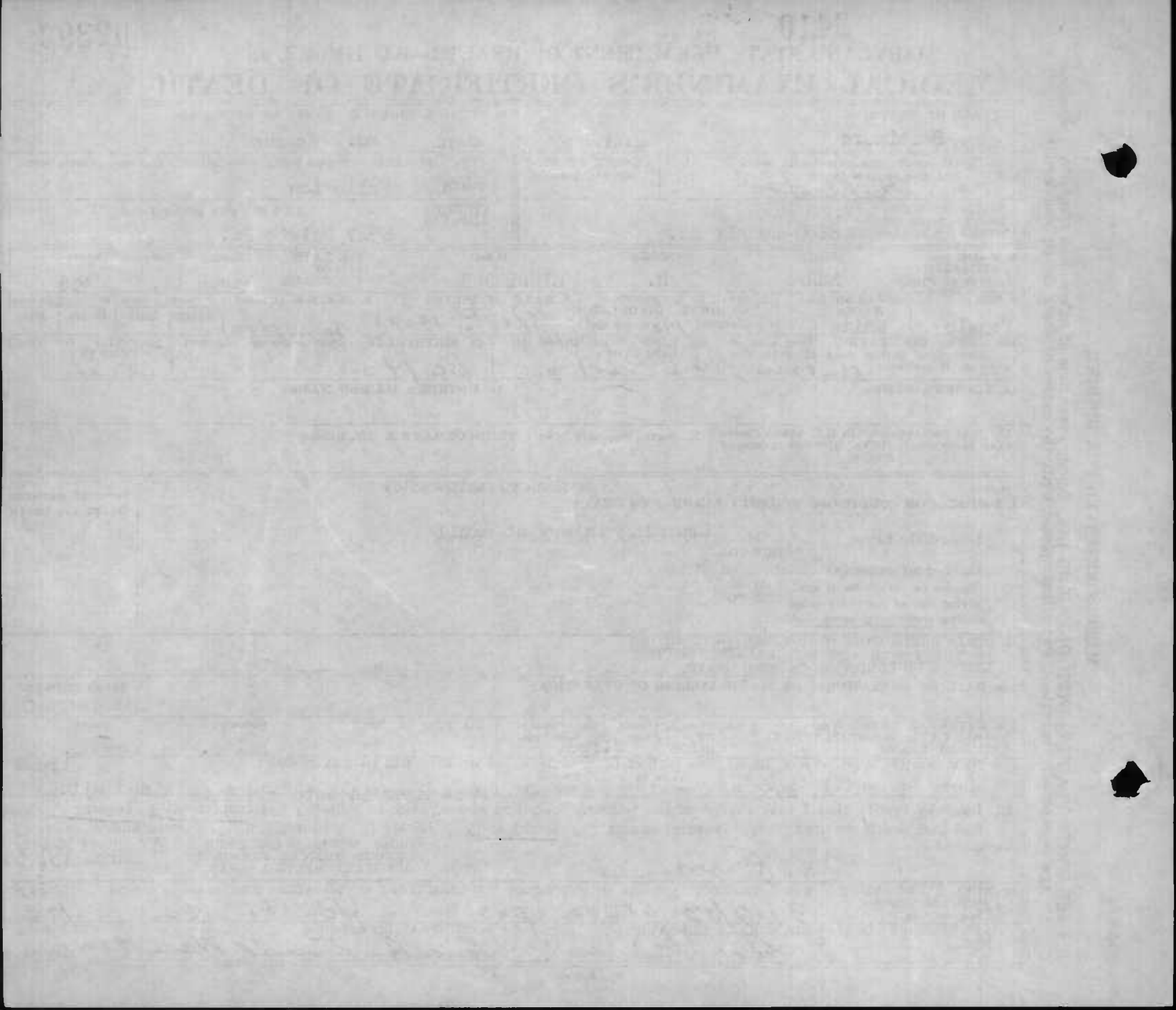
2410
Film 179 3-28-55 et

02392
Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 43

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Fullerton</u> TOWN <u>Fullerton</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8300 Belair Rd.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Fullerton</u> TOWN <u>Fullerton</u> STREET ADDRESS (If rural, give location) <u>8327 Belair Rd.</u>			
3. NAME OF DECEASED: (Type or Print) <u>AGNES</u>		(First) <u>H.</u> (Middle) <u>LINDMORE</u> (Last)		4. DATE OF DEATH <u>March 14, 1955</u> (Month) (Day) (Year)			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Married</u>			
8. DATE OF BIRTH: <u>5/15-26/1904</u>		9. AGE last birthday: <u>52 1/2</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Matron</u>			
11. BIRTHPLACE (State or foreign country): <u>Balto.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME:			
14. MOTHER'S MAIDEN NAME:		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:			
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>816X</u> Immediate cause (a) <u>Crushing injury of skull</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) _____				INTERVAL BETWEEN ONSET AND DEATH			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				19a. DATE OF OPERATION: 19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					
21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>street</u>		21c. (City or town) <u>Balto.</u> (County) <u>Md.</u> (State) <u>83</u>		21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>March 14, 1955 M.</u>			
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>truck</u> <u>Passenger in auto which collided with</u>					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>J.P. Fisher</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>March 15, 55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3/17/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Josephs</u>			
LOCATION (City, town, or county) <u>Balto. Co.</u> (State) <u>Md.</u>		DATE REC'D BY LOCAL REG. <u>3-16-55</u>		REGISTRAR'S SIGNATURE <u>Dr. H. K. ...</u>			
24. FUNERAL DIRECTOR <u>Laurel Funeral Home</u>		ADDRESS <u>4401 Belair Rd.</u>					



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2411

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

02883

No. 43

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>TOWN Fullerton</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Fullerton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8800 Belair Rd.</u>				STREET ADDRESS (If rural, give location) <u>8327 Belair Rd.</u>			
3. NAME OF DECEASED: (Type or Print) <u>FORREST L. LINDIMORE</u>				4. DATE OF DEATH (Month) <u>March</u> (Day) <u>14</u> (Year) <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>2/5/1902</u>	9. AGE last birthday: <u>53</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Sanitation</u>		11. BIRTHPLACE (State or foreign country): <u>Ohio</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Lindimore</u>				14. MOTHER'S MAIDEN NAME:			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>yes</u>		16. SOCIAL SECURITY No.: <u>World War II 216-24-1315</u>		17. INFORMANT & ADDRESS: <u>Geo. Schwenker 8327 Belair Rd</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p>Immediate cause (a) <u>Crushing injury of chest and head</u></p> <p style="text-align: center;">DUE TO</p> <p>Antecedent cause(s) (b) _____</p> <p>Diseases or conditions, if any, giving rise to the above cause DUE TO _____</p> <p>stating underlying cause last (c) _____</p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) <u>Street</u>		21c. (City or town) (County) (State) <u>Balto.</u> <u>03</u> <u>Md.</u>			
21d. TIME (Month) (Day) (Year) (Hour) <u>March 14, 1955</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Driver of auto collided with truck</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Dr. Fisher</u>		M. D. ASSISTANT MEDICAL EXAM. <u>3/15/55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3/17/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Josephs</u>		LOCATION (City, town, or county) (State) <u>Balto. Co.</u> <u>Md</u>	
DATE REC'D BY LOCAL REG. <u>3-16-55</u>		REGISTRAR'S SIGNATURE <u>W. Federal</u>		24. FUNERAL DIRECTOR <u>Passan Funeral Home</u> ADDRESS <u>4409 Belair</u>			

10034

42

1942

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

TO: [Illegible]
FROM: [Illegible]
SUBJECT: [Illegible]
[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a memorandum or report containing several paragraphs of text, possibly including dates, names, and descriptive information. The text is organized into a formal document structure with headings and body paragraphs.]



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02394

2412

CERTIFICATE OF DEATH

Reg. Dist. No. 30

Item 8, Film 179 3-21-55 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTO CO.</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>BALTO.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
52 TOWN <u>CATONSVILLE</u>	<u>LIFE</u>	TOWN <u>CATONSVILLE</u> 52	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
4 HOWARD AVE.		4 HOWARD AVE.	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) (Middle) (Last)		OF DEATH: <u>MARCH 6 1955</u>	
<u>CHARLES E. LONG</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: 1875
<u>M</u>	<u>W</u>	<u>MARRIED</u>	<u>FEB. 14, 1876</u>
9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>80</u> yrs.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even retirement)		10B. KIND OF BUSINESS OR INDUSTRY	
<u>CLERK SPRING LAKE HOSP</u>		<u>MD.</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>MD.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>JOHN LONG</u>		<u>CRONHARDT</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>NO</u>			
17. INFORMANT & ADDRESS:			
<u>ANNA MARGARET LONG</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>			<u>several minutes</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerotic cardiovascular disease</u>			<u>several years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb 27, 1954</u> to <u>March 6, 1955</u> , that I last saw the deceased alive on <u>Feb 28, 1955</u> , and that death occurred at <u>9:15 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Johna MacNabb, Jr.</u>		ADDRESS <u>M. D. 1118 St. Paul St. Balt. 2nd</u>	
DATE SIGNED <u>3-9-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>WOODLAWN MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-9-55</u>		REGISTRAR'S SIGNATURE <u>J.E. Harry</u>	
24. FUNERAL DIRECTOR		ADDRESS	
<u>MACNABB & SON</u>			

RECEIVED

MAR 11 1955

BUREAU V. S.

CERTIFICATE OF DEATH

Reg. Dist. No. 44

Item 9, Film G179 4-1-55 et

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edgemere</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Edgemere</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location) <u>2513 Tepees Lane</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Henry</u> <u>Long</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 12th 1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Colored</u>	7. SINGLE , MARRIED, WIDOWED, DIVORCED , (Specify)	8. DATE OF BIRTH <u>April 12th 1896</u>
9. AGE last birthday <u>58</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Steel mills</u>	11. BIRTHPLACE (State or foreign country) <u>Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	13. FATHER'S NAME <u>Abraham Long</u>	14. MOTHER'S MAIDEN NAME <u>Emma Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO. <u>213-092741</u>	17. INFORMANT AND ADDRESS <u>Dorothy Branch 7815 Sparrow St Baltimore 19 Md</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

492X

Immediate cause

(a)

Virus Pneumonia

INTERVAL BETWEEN ONSET AND DEATH

1 Wk.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Hypertension, arteriosclerosis & Enlarged Heartunknown

(c)

II. OTHER SIGNIFICANT CONDITIONS

Diseases or conditions, if any, related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, or office bldg., etc.)
OF INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☒ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from October, 1954, to March 12, 1955, that I last saw the deceasedalive on March 12th 1955, and that death occurred at 2:15 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION RE MOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

J. H. Thomas MD. 107 N. Main St Balto 22 Md 3/12/55

Burial 3-15-55 Mt Calvary A. G. Co Md

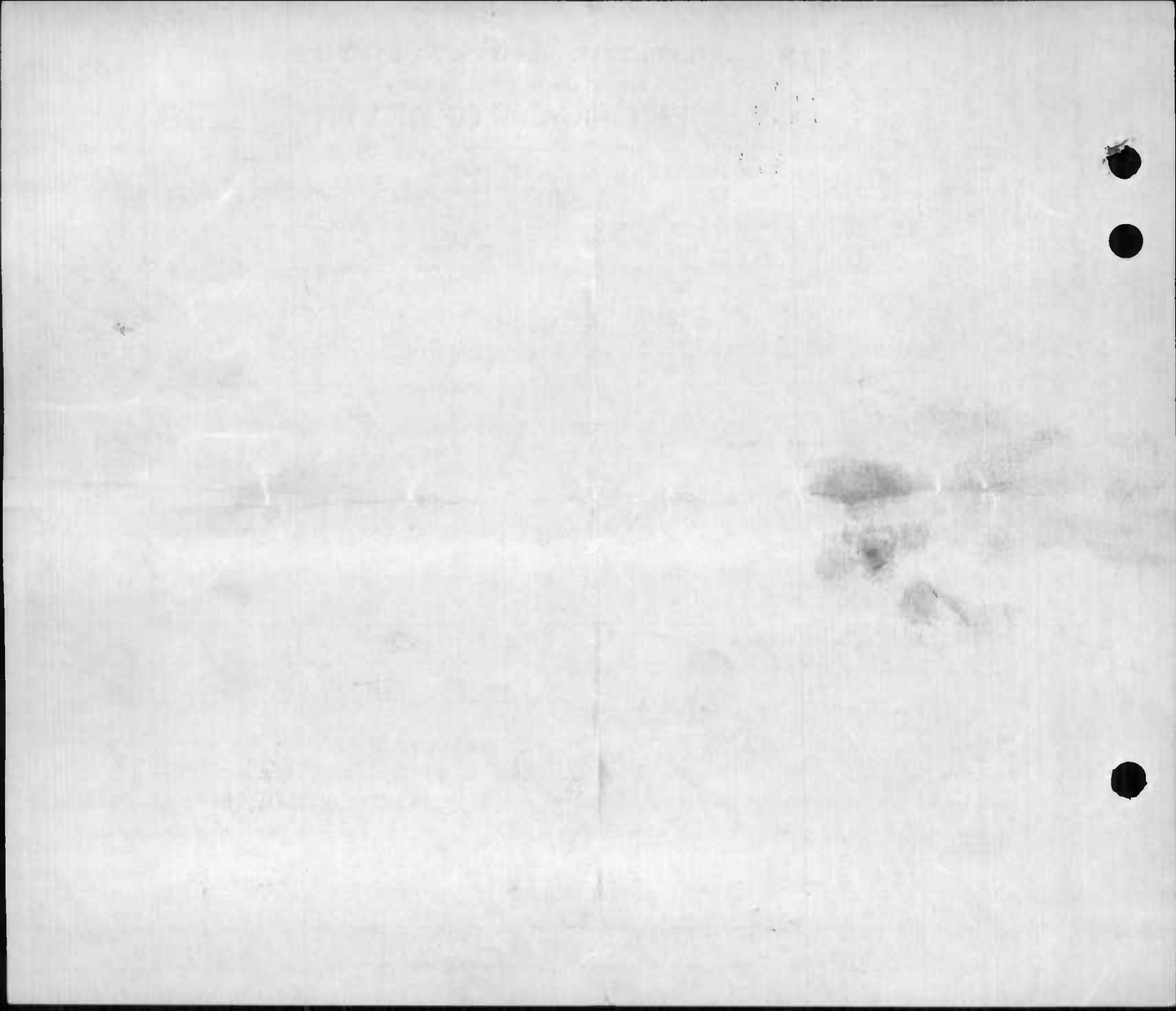
2-15-55 A. G. Sanders Rayner Sanders

217 E. Preston St, Balto Md

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2316

CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
53 <u>DUNDALK - (22)</u>		<u>29</u>		<u>DUNDALK 22</u>		<u>53</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>62 BROADSHIP</u>				<u>62 BROADSHIP</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>MARY SCANNETT LONG</u>				<u>3-13-1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>F.</u>		<u>W.</u>		<u>MARRIED</u>		<u>5 DEC. 1903</u>	
9. AGE last birthday: (If UNDER 1 YEAR) (If UNDER 24 HRS.)				10. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:			
<u>51</u> yrs. Months Days Hours Min.				<u>HOUSEWIFE</u>			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
<u>W. VA.</u>				<u>U. S. A.</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>ROLFE O. DUVAL</u>				<u>EMMA SHEPHER</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY No.:			
<u>NO</u>				<u>214-22-8975</u>			
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
<u>WM. J. LONG - 62 BROADSHIP</u>				<p>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p><u>422.2</u></p> <p>Immediate cause (a) <u>MASSIVE Pulmonary Embolus</u></p> <p>DUE TO (b) <u>Myocarditis Chronic</u></p> <p>Antecedent causes (s) <u>Aneurysm Fibellatin</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.</p>			
11. OTHER SIGNIFICANT CONDITIONS				20. AUTOPSY ?			
Conditions contributing to the death but not related to the disease or condition causing death.				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
<u>3-16-55</u>				<u>MASSIVE Pulmonary Embolus</u>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.)		(CITY OR TOWN)		(COUNTY)	
<u>INJURY</u>		<u>Home</u>		<u>DUNDALK</u>		<u>BALTO. CO.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR ?			
<u>March 8, 1955</u>		<u>While at Work</u>		<u>3/13/55</u>			
22. I hereby certify that I attended the deceased from <u>March 8, 1955</u> to <u>March 13, 1955</u> , that I last saw the deceased alive on <u>March 8, 1955</u> , and that death occurred at <u>2:40 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William M. Kelly</u>				DATE SIGNED <u>3/13/55</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>3-16-55</u>		<u>SACRED HEART</u>		<u>BALTO. CO. MD.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>March 14-1955</u>		<u>William M. Kelly</u>		<u>Robert Bradley, Dundalk, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

MAR 16 1955

RECEIVED

2414

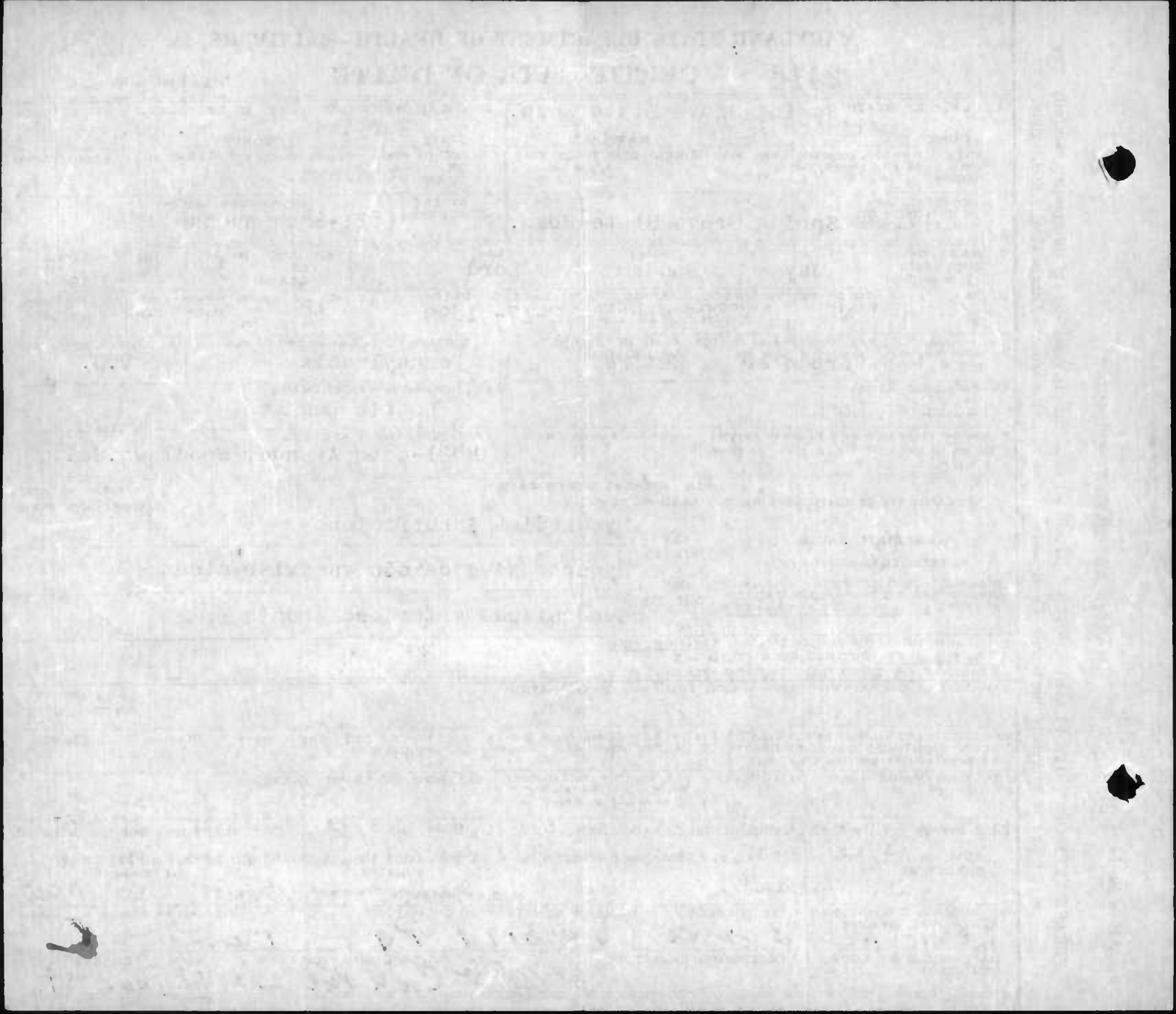
CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH: Spring Grove State Hosp. COUNTY Baltimore MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: Maryland Pr. Geo. STATE COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) 52 Catonsville		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Woodlawn, 16X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hosp.		STREET ADDRESS (If rural give location) 6821-68th Avenue	
3. NAME OF DECEASED: (First) Jay (Middle) Bonham (Last) Lord		4. DATE (Month) (Day) (Year) OF DEATH: 3 22 1955	
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married	8. DATE OF BIRTH: 2-17-1890
9. AGE last birthday: 65 yrs.		10. IF UNDER 1 YEAR: Months Days	11. IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter		10B. KIND OF BUSINESS OR INDUSTRY: Retired	
11. BIRTHPLACE (State or foreign country): Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: William Lord		14. MOTHER'S MAIDEN NAME: Lottie Bonham	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: 4821-68th Avenue, Woodlawn.Md.			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
443X IMMEDIATE CAUSE			1 day
(A) DUE TO Myocardial insufficiency			
ANTECEDENT CAUSE (S):			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(B) DUE TO Hypertensive cardio vascular disease			
(C) DUE TO Generalized arteriosclerosis			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)	
21D. TIME (Month) (Day) (Year) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 2/1, 1955, to 3/22, 1955, that I last saw the deceased alive on 3/22, 1955, and that death occurred at 3:54 P.M. from the causes and on the date stated above.			
SIGNATURE S. Wacheler		ADDRESS M.D. Spring Grove St. Hospital DATE SIGNED 3/22/55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Removal	3-22-55	Cambria Pa	Pa.
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
3-22-55	A. W. [Signature]	Coolidge 1217 St. Paul St.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

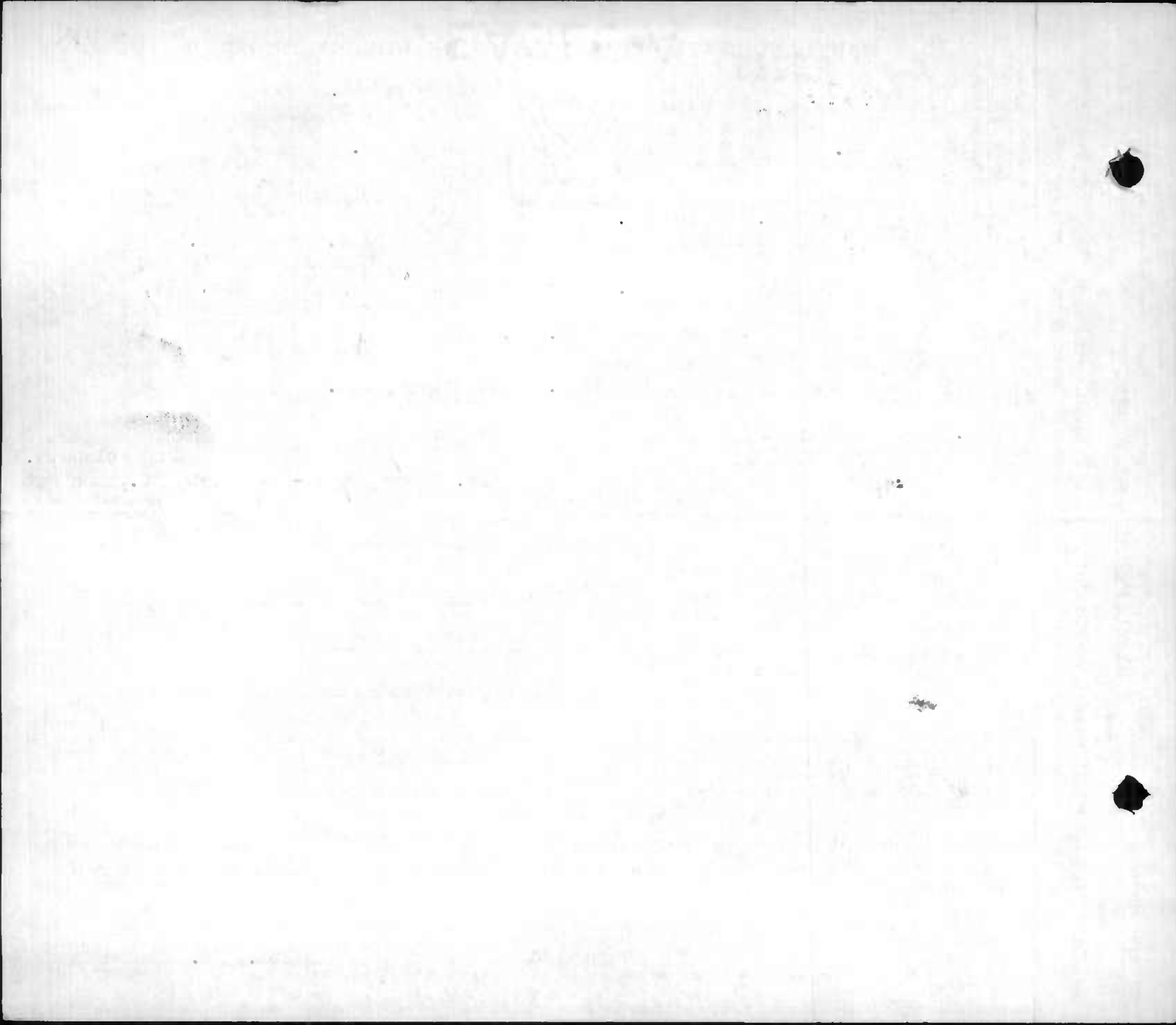
02398

CERTIFICATE OF DEATH

Reg. Dist. No. 30

Item 12, File G179 3-31-55 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 TOWN Catonsville</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>3601-4 TOWN Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 1102 N. Rolling Rd. Shady Nook Nursing Home</u>		STREET ADDRESS (If rural give location) <u>20 E. Preston St.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WILLIAM A. MacGREGOR</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar. 21, 1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Mar. 11, 1874</u>
		9. AGE last birthday <u>81</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant (rtd)</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Typewriter Mfr.</u>	11. BIRTHPLACE (State or foreign country): <u>Woodstock, Can.</u>
13. FATHER'S NAME: <u>Rev. Malcom MacGregor</u>		14. MOTHER'S MAIDEN NAME: <u>Belinda Pavey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>Long Island, N.Y.</u>	
17. INFORMANT & ADDRESS: <u>Mrs. Nancy Getman-57-51 79th St., Elmhurst</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
420.1 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>			<u>3 hr</u>
ANTECEDENT CAUSE (S) DUE TO (B) <u>arterio sclerosis</u>			<u>year</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Myocarditis</u>			<u>year</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While Not while at work at work	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 24, 1954</u> to <u>March 21, 1955</u> that I last saw the deceased alive on <u>March 21, 1955</u> , and that death occurred at <u>1399</u> M, from the causes and on the date stated above.			
SIGNATURE <u>Loisimke For.</u>		ADDRESS <u>1115 St. Paul St.</u> DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>3/25/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Greenmount</u>		LOCATION (City, town, or county) (State) <u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-24-55</u>		REGISTRAR'S SIGNATURE <u>E. W. Hedrick</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Pickner & Sons</u>		ADDRESS <u>Balto.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

2416

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>WOODLAWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1906 THAYER TERRACE</u>		STREET ADDRESS (If rural, give location) <u>1906 THAYER TERRACE</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>ARTHUR S. MAULER</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M.</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>MARCH 14 1955</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>BETHLEHEM STEEL CO. (Retired)</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>MA</u>	8. DATE OF BIRTH <u>FEB. 4 1890</u>	9. AGE last birthday <u>65</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>CONRAD MAULER</u>	
14. MOTHER'S MAIDEN NAME <u>MAY ?</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>YES</u> <u>I</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. RHODA MAULER 1906 THAYER TERRACE (?)</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
491X Immediate cause	(a) <u>Terminal Bronchopneumonia</u>	<u>3 days</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b) _____	
(c) _____		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		<u>5 years</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Mar 1, 1955, to Mar 14, 1955, that I last saw the deceased alive on Mar 14, 1955, and that death occurred at 9 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>BURIAL</u>	<u>3/17/55</u>	<u>BALTIMORE NATIONAL</u>	<u>BALTIMORE</u>	<u>MD</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>3-16-55</u>	<u>Aug. C. Borsall</u>	<u>J.T. STANSBURY</u>	<u>6411 WINDSOR mill RD (7)</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 17 1955

BUREAU V. S.

2417

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND		COUNTY BALTIMORE	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN BROOKLANDVILLE			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 VALLEY + JOPPA ROADS				STREET ADDRESS (If rural give location) VALLEY + JOPPA ROADS			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
LILLY CATHERINE Mc CAFFREY				MAR. 9, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
FEMALE	WHITE	WIDOWED	FEB. 1, 1865	90 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
HOUSEWIFE		OWN HOME		MARYLAND		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
JOHN A. SOMMERVILLE				ELLEN CATHERINE FISHER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
No		NONE		FAMILY RECORDS			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
490X IMMEDIATE CAUSE				(A) Pneumonia, Lobar			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) Hemiplegia, Left			
				DUE TO			
				(C) Cerebral. Hemorrhage			
				Interdifferential Cerebral			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				General			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
2. I hereby certify that I attended the deceased from 2/28 , 19 55 , to 3/9 , 19 55 , that I last saw the deceased alive on 3/8 , 19 55 , and that death occurred at 5:15 AM , from the causes and on the date stated above.							
SIGNATURE Bennett A. Stoen		M.D. Hucherville		DATE SIGNED 3/9/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		MAR. 12, 1955		ST. JOHN'S CEMETERY		WESTMINSTER, CARROLL CO, MD	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
3/4/55		H. H. Zeman		John Burnett Stoen, Towson, Md.			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

TO THE SECRETARY OF THE INTERIOR
FROM THE COMMISSIONER OF THE GENERAL LAND OFFICE
SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a formal report or correspondence.]

[The following text is also extremely faint and largely illegible. It appears to be the main body of the document, possibly containing details of land transactions or survey results.]

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

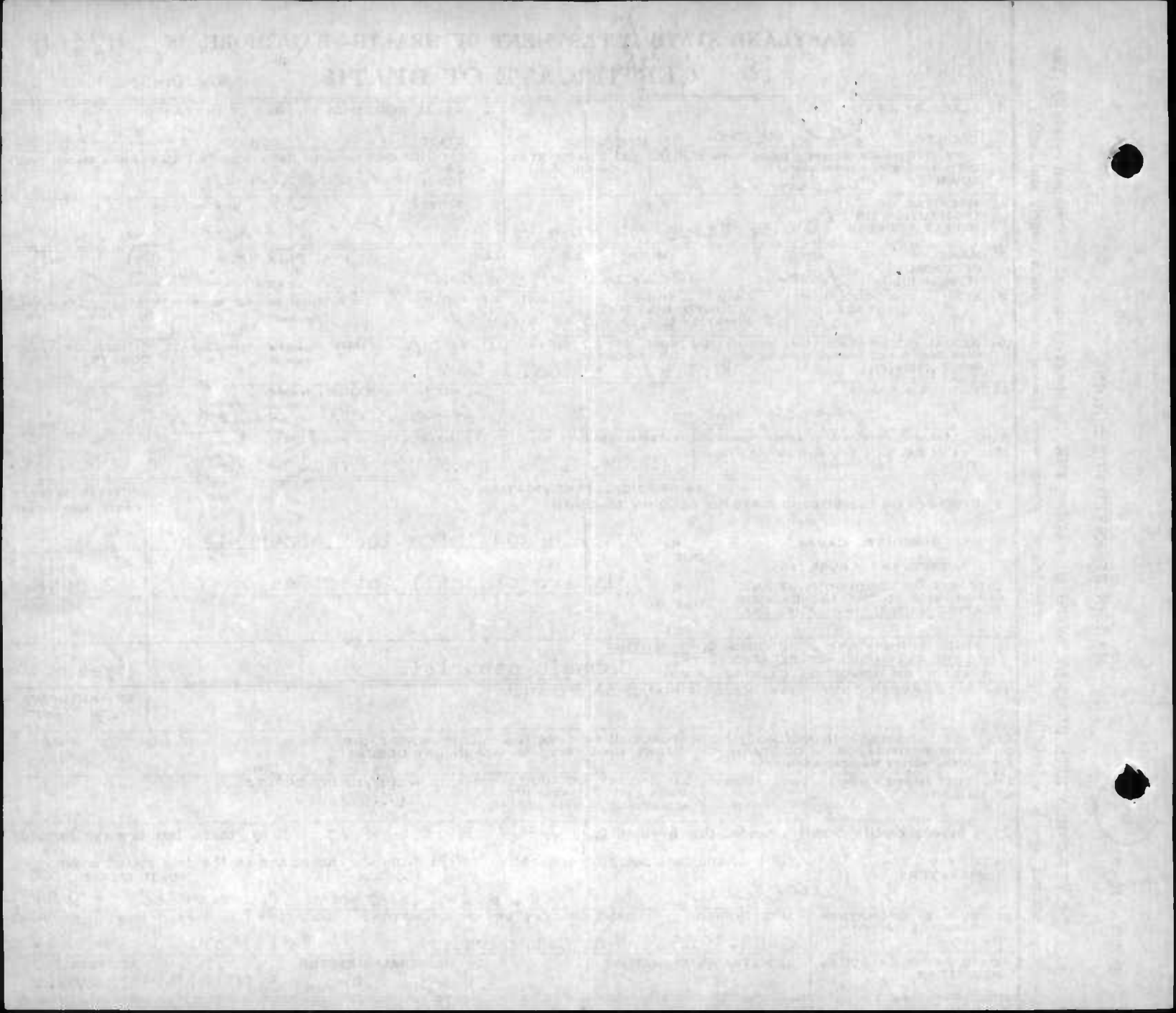
02400

2418

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>52 Calomville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove St. Hospital</u>				STREET ADDRESS (If rural give location) <u>3406 Walbrook Ave</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>James Samuel McComb</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>3 19 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>11/4/1978</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Watchman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>U.S.F. & G. Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James McComb</u>				14. MOTHER'S MAIDEN NAME: <u>Susan Mc Dermott</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service) <u>215-07-8120</u>		17. INFORMANT & ADDRESS: <u>Mrs. Marie S. Malone 3406 Walbrook Av.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>570.3 Toxemia and intestinal obstruction</u>						2 days	
ANTECEDENT CAUSE (B) <u>Volvulus of small intestine</u>						2 days	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C) <u>Chronic nephritis</u>						years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 3</u> , 1954, to <u>3/19</u> , 1955, that I last saw the deceased alive on <u>3/19</u> , 1955, and that death occurred at <u>9:00 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>3. Wachser</u>				ADDRESS <u>M.D. Spring Grove St. Hospital</u>		DATE SIGNED <u>3/19/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-22-1955</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-21-55</u>		REGISTRAR'S SIGNATURE <u>A/S</u>		24. FUNERAL DIRECTOR ADDRESS <u>G. Howard Strong 3207 W. North Ave.,</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

02401

2419

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY BALTIMORE MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE MD. COUNTY A.A.CO.	
CITY (If outside corporate limits, write RURAL and give nearest town) CATONSVILLE		CITY (If outside corporate limits, write RURAL and give nearest town) BROOKLYN	
TOWN CATONSVILLE		TOWN BROOKLYN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS HOUSE IN THE PINES 16 FUSTING AVE		STREET ADDRESS (If rural, give location) 8 W. 2ND AVE BROOKLYN PARK.	
3. NAME OF DECEASED (Type or Print) BYRD	(First) W. (Middle) MC DONALD (Last)	4. DATE OF DEATH (Month) (Day) (Year) MARCH 26 1955	
5. SEX M.	6. COLOR OR RACE W.	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWER	8. DATE OF BIRTH OCT. 1, 1879
9. AGE last birthday 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED	
11. BIRTHPLACE (State or foreign country) VA.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME STEPHEN D. MC DONALD		14. MOTHER'S MAIDEN NAME SIDNEY KEARNS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 578-01-3911	
17. INFORMANT AND ADDRESS MRS EDWIN C. WEAVER, 702 WINANS WAY			

13. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

420.1 Immediate cause (a) **Coronary occlusion due to advanced arteriosclerotic cardiovascular disease with myocardial degeneration**

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

3 hrs

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.**Bronchopneumonia, severe**

3 days

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **10 Feb.**, 19**52**, to **26 Mar.**, 19**55**, that I last saw the deceased alive on **25 Mar.**, 19**55**, and that death occurred at **3:02 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

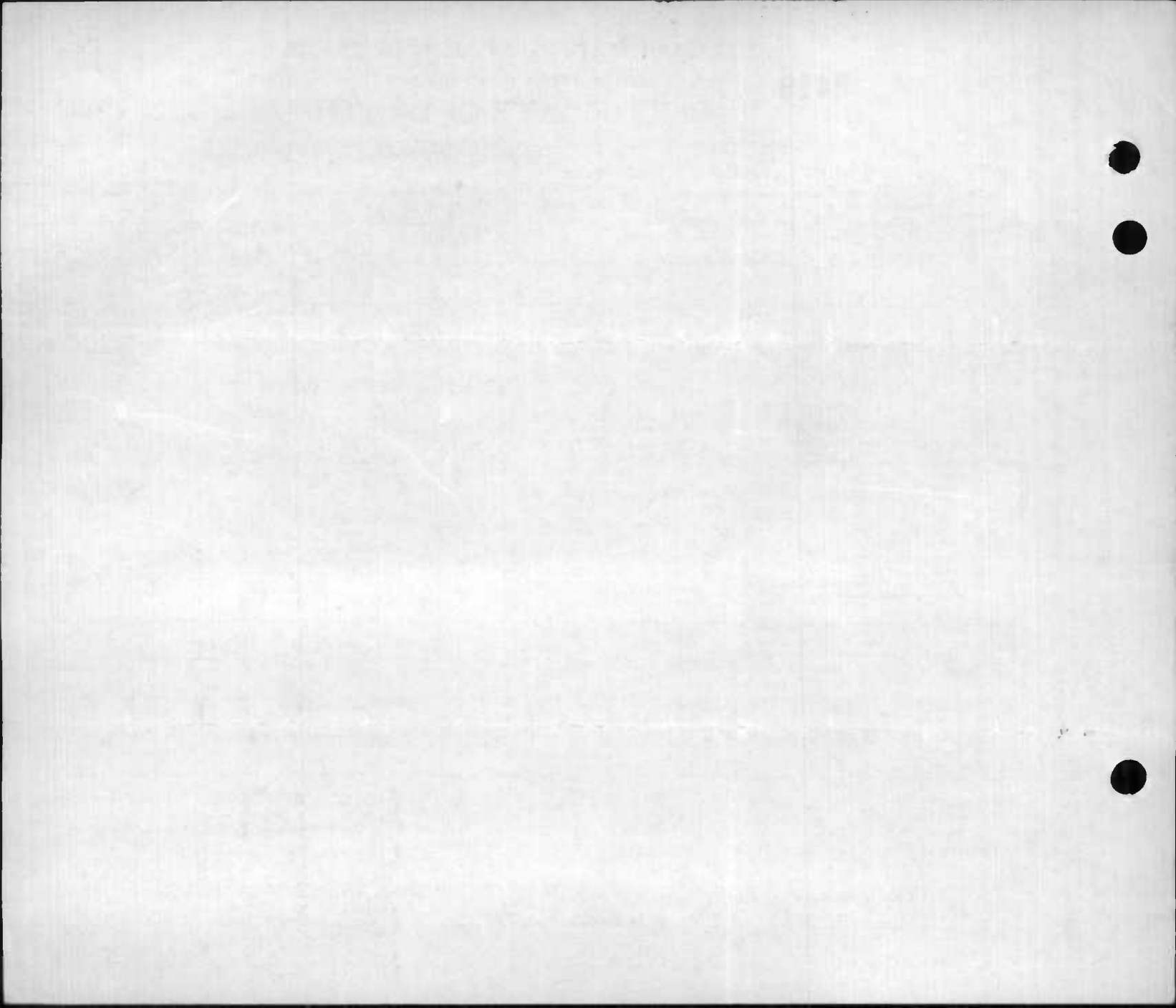
DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) BURIAL	DATE THEREOF MAR. 29/55	NAME OF CEMETERY OR CREMATORY CEDAR HILL	LOCATION (City, town, or county) A.A.CO.	(State) MD.
DATE REC'D BY LOCAL REG. 3/29/55	REGISTRAR'S SIGNATURE L	24. FUNERAL DIRECTOR Harry H. Witzke	ADDRESS 4101 EDMONDSON AVE.	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2420
CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:

Baltimore

COUNTY

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) Towson

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Presbyterian Home

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md.

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town) OR Baltimore 3001-4

STREET ADDRESS

(If rural, give location) 4315 Garrison Ave. ✓

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

Susanna Jamison McLean

4. DATE OF DEATH:

(Month)

(Day)

(Year)

March 10,

19 55

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single

8. DATE OF BIRTH: May 13, 1870

9. AGE last birthday: 84 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): retired credit manager of Dept. store

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

John J. McLean

14. MOTHER'S MAIDEN NAME:

Rose

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

Records-Presbyterian Home Towson, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

442X
Immediate cause

(a) DUE TO

Cardio-Renal-Vascular disease

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

Senile changes
Arteriosclerosis

(c)

INTERVAL BETWEEN ONSET AND DEATH

4 1/2 +

Unk.
Unk.

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 1951, to March 1955, that I last saw the deceased alive on 3/3, 1955, and that death occurred at 11:30 P.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, or other disposal (Specify): Burial

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

March 14, 1955

Woodlawn

Woodlawn,

Md.

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

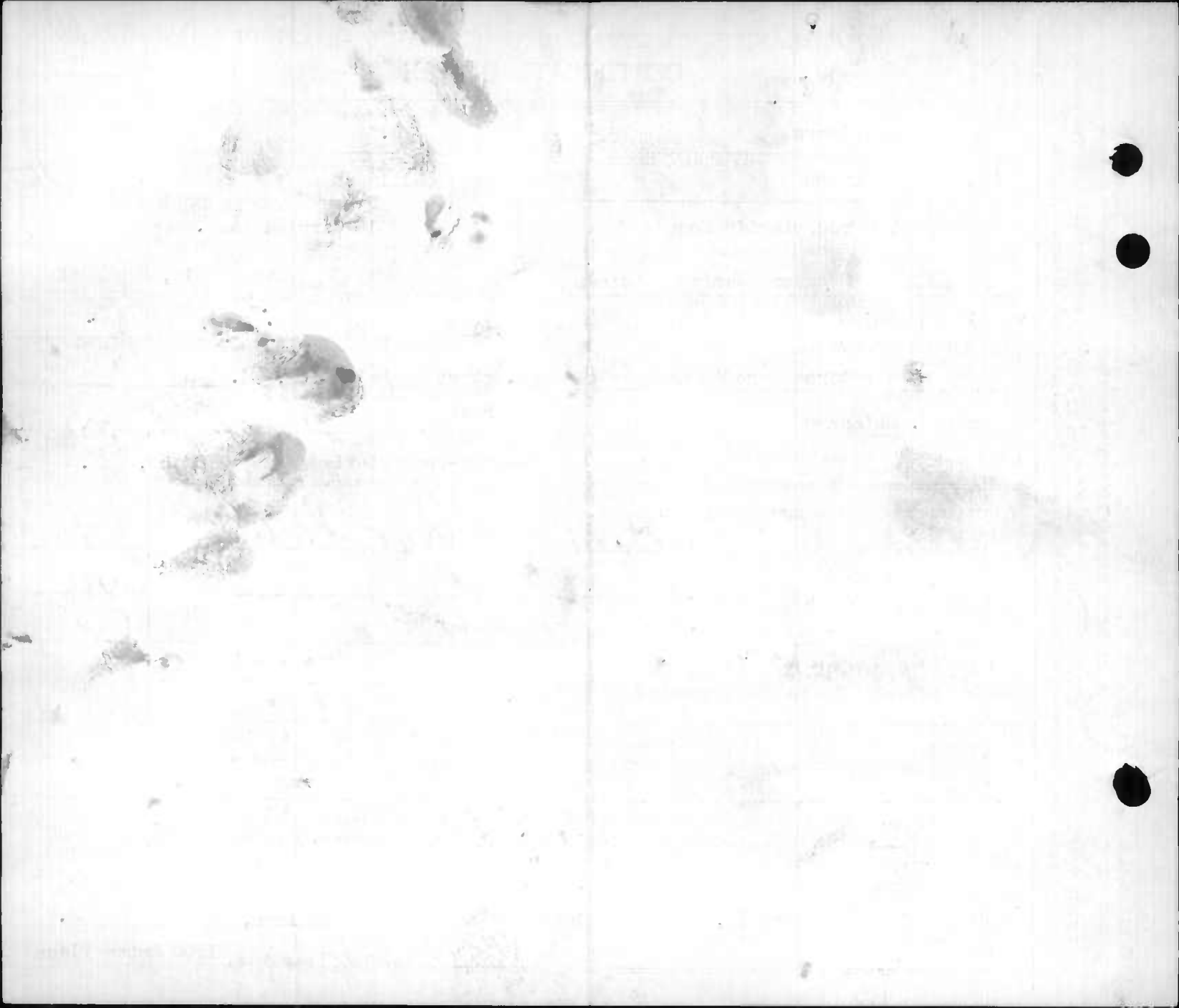
ADDRESS

MAR 12 1955

C. Mitchell

John O. Mitchell & Sons Inc. 1900 Eutaw Place

MARGIN RESERVED FOR BINDING



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02403
2421 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Paradise Nursing Home</u>				STREET ADDRESS (If rural give location) <u>327 S. Payson St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Julia</u> <u>McSweeney</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>Mar.</u> <u>7</u> <u>1955</u>			
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Mar. 20, 1876</u>	9. AGE last birthday: <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Daniel McSweeney</u>				14. MOTHER'S MAIDEN NAME: <u>Hannah Eney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY No.: <u>212-01-6008</u>		17. INFORMANT & ADDRESS: <u>Mrs. J. Burk Little 722 Edgewood St.</u>			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
422.1 Immediate cause (a) <u>Anterior Septal Myocardial Infarction</u>		4 mos.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Arterio Sclerotic Chronic Vascular Disease</u>		10/3/52
(c)		

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	

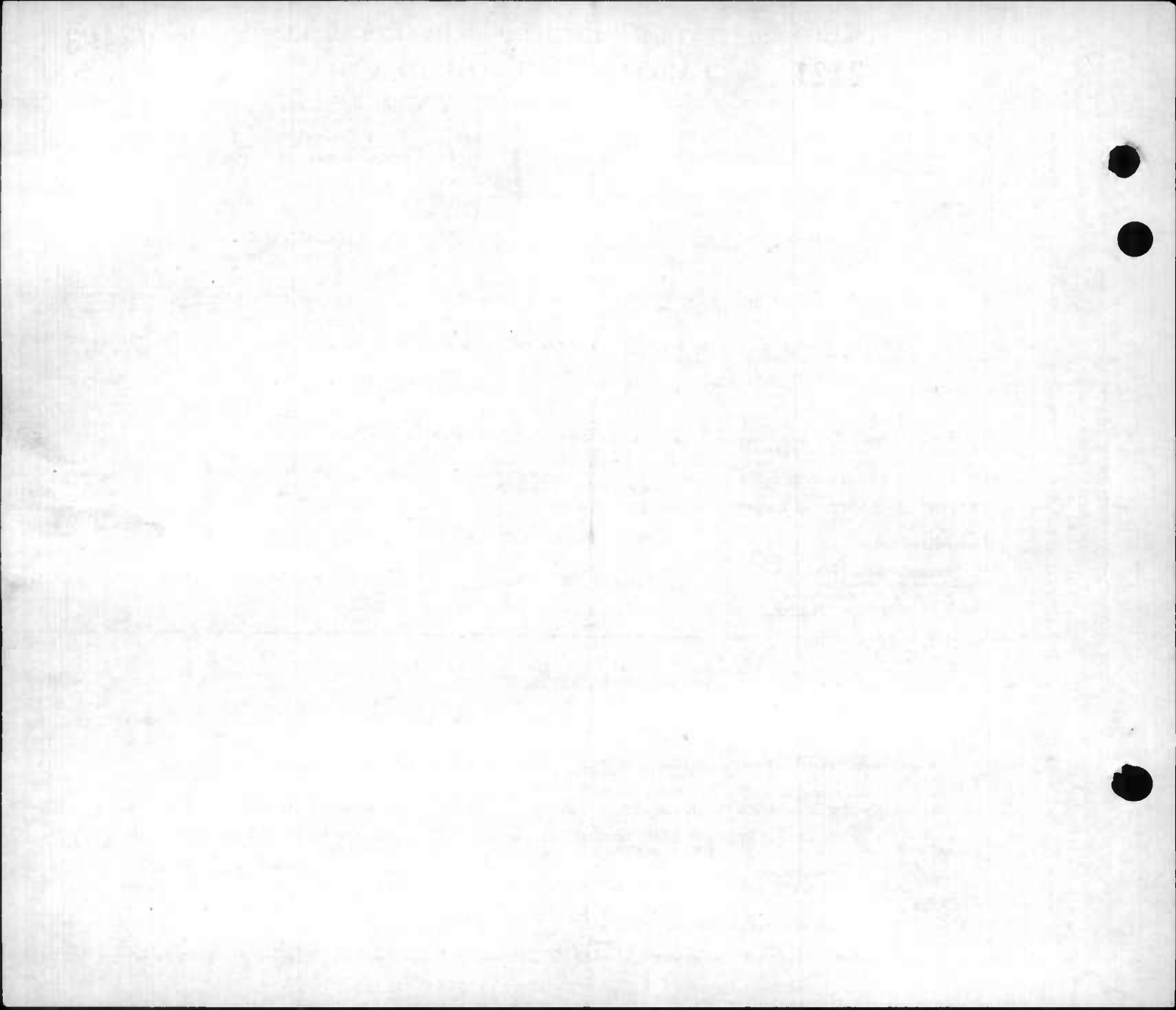
22. I hereby certify that I attended the deceased from March 1947, to March 7, 1955, that I last saw the deceased alive on March 6, 1955, and that death occurred at 5:30 AM, from the causes and on the date stated above.

SIGNATURE Daniel E. Conrad, M.D. (Degree or title) ADDRESS 1905 W. 13th more St. Balto; 29-Md. DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Mar. 10, 1955</u>	<u>Western Cemetery</u>	<u>Baltimore, Md.</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3/9/55</u>	<u>D.W. Hedrick</u>	<u>R. B. Murphy</u>	<u>1301 Eastern Ave</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2422
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Regd 12404
 No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Catonsville</u>		3mo. 8 days		TOWN <u>Baltimore</u>		02X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS (If rural, give location) <u>302 Riverside Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Howard Milton Miller</u>				<u>March 11 19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>6-15-1903</u>	<u>51</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Glass worker - Swindell Co.</u>				11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Albert Miller</u>				14. MOTHER'S MAIDEN NAME: <u>Sophia Kaisier</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u> <u>Yes</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
231X Immediate cause (a) <u>Congestive heart failure</u> DUE TO							
Antecedent cause(s) (b) <u>due to</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) <u>Mediastinal tumor or growth</u>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Geo. McKieffer</u>		1010 Leids on		CHIEF MEDICAL EXAMINER		DATE SIGNED <u>3-11-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF <u>3/15/55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore Nat.</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
DATE RECEIVED BY LOCAL REG. <u>1-11-1955</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>James L. McCully - 130 E. Fort Ave.</u>		ADDRESS	

02405

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 45

2423

1. PLACE OF DEATH- COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Middle River</u> LENGTH OF STAY (in this place) <u>74 yrs</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Middle River</u> 54	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>18 Cockpit St.</u>		STREET ADDRESS (If rural give location) <u>18 Cockpit St</u>	
3. NAME OF DECEASED (Type or Print) <u>Phebe</u>	(First) <u>M.</u> (Middle) <u>Miller</u> (Last)	4. DATE OF DEATH (Month) <u>3</u> (Day) <u>2</u> (Year) <u>1953</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>12/23/1869</u>
9. AGE last birthday <u>85</u> yrs.		10. AGE last birthday If under 1 year (Month) (Day) (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Pa</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Bottorf</u>		14. MOTHER'S MAIDEN NAME <u>Jane Bateman</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT <u>Foster Miller</u>		<u>18 Cockpit St.</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Cardiac arrest</u>		
Antecedent cause(s) (b) <u>cerebro-vascular accident</u>		<u>2 day</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>arterio-sclerotic cerebrovasculardisease</u>		<u>20 yrs</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1952, to March 2, 1955, that I last saw the deceased alive on March 2, 1955, and that death occurred at 10:45 P.m., from the causes and on the date stated above.

SIGNATURE <u>Lois Semeroff</u>	(Degree or title) <u>MD</u>	ADDRESS <u>1437 Furley Ave, Balto 20, Md</u>	DATE SIGNED
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>3/5/55</u>	NAME OF CEMETERY OR CREMATORY <u>GRAY GARDVIEW CEM.</u>	LOCATION (City, town, or county) (State) <u>PENNA.</u>
DATE REC'D BY LOCAL REG. <u>3/7/5</u>	REGISTRAR'S SIGNATURE <u>Edith Hurley</u>	24. FUNERAL DIRECTOR <u>Sassaohn Funeral Home</u>	ADDRESS <u>7401 Belair Rd</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 11 1966

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2424 CERTIFICATE OF DEATH

02406

Reg. Dist. No. *XX*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>X</i> TOWN <u>Fort Howard</u>		LENGTH OF STAY (In this place) <u>2 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <i>3 Vol-4</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>50</i> <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>3743 Nortonia Rd.</u> <i>✓</i>					
3. NAME OF DECEASED: (First) (Middle) (Last) <u>FRANK H. MILLS, JR.</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>March 13</u> <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>2/27/92</u>	9. AGE last birthday: <u>63</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salesman</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Stationary</u>		11. BIRTHPLACE (State or foreign country): <u>New York, N.Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Frank D Mills</u>				14. MOTHER'S MAIDEN NAME: <u>May R. Hodgkins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>✓</i> <u>Yes</u> (If Yes, give war or dates of service) <u>WW-II</u>		16. SOCIAL SECURITY NO. <u>212 16 2212</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<i>443X</i> IMMEDIATE CAUSE (A) <u>CEREBROVASCULAR ACCIDENT</u>						<u>2 Weeks</u>	
ANTECEDENT CAUSE (B) DUE TO <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 11, 1955</u> , to <u>Mar. 13, 1955</u> , that I last saw the deceased <u>alive</u> and that death occurred at <u>1:10 AM</u> , from the causes and on the date stated above.							
SIGNATURE <i>C. Gonzalez, M.D.</i>		ADDRESS <u>VAH, Fort Howard, Md.</u>		DATE SIGNED <u>3/13/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-16-1955</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-15-55</u>		REGISTRAR'S SIGNATURE <i>Howard G. Strong</i>		24. FUNERAL DIRECTOR <u>Howard G. STRONG</u>		ADDRESS <u>Funeral Home 3207 W. North Ave. Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

OFFICE OF THE ASSISTANT SECRETARY

FOR PUBLIC HEALTH

WASHINGTON, D. C.

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02407

44

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> -19 <u>MARYLAND</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>in</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1311 Sparrows Pt. Rd.</u>		STREET ADDRESS (If rural, give location) <u>#1</u>	
3. NAME OF DECEASED (Type or Print) <u>STEVE</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>May. 24, 1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED <u>Married</u>	8. DATE OF BIRTH <u>Aug. 6, 1896</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tavern owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tavern</u>	9. AGE last birthday <u>58</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Mimides</u>		14. MOTHER'S MAIDEN NAME <u>Ardue (last name unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>Nagle Mimides wife. address. as in #1.</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
141X Immediate cause (a) <u>Inanition</u>	(b) <u>Adeno carcinoma tongue</u>	<u>2 wks.</u>
Antecedent cause(s) (c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		<u>14 mo.</u>

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>Aug.</u> , 19 <u>52</u> , to <u>May 24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Mar. 23</u> , 19 <u>55</u> , and that death occurred at <u>11: A</u> m., from the causes and on the date stated above.	
SIGNATURE <u>Lois N. Hollen M.D.</u>	DATE SIGNED <u>3/24/55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>3/28/55</u>
NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cemetery</u>	LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>
DATE RECEIVED BY LOCAL REGISTRAR'S SIGNATURE <u>March 26-55</u>	24. FUNERAL DIRECTOR <u>Ulrich Funeral Home 2112 Dundalk Ave</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 29 1955

RECEIVED

02408

2426 MARYLAND STATE DEPARTMENT OF HEALTH CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

Reg. Dist. No. 449

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <u>Sparrows Point</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Sparrows Point</u> 19 X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bethlehem Steel Plant</u>		STREET ADDRESS (If rural, give location) <u>1018 H Street</u>	
3. NAME OF DECEASED (Type or Print) <u>PAUL</u> (First) <u>Wilbur</u> (Middle) <u>Morris</u> (Last)		4. DATE OF DEATH <u>March 21, 1955</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 13 1900</u> 54 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Welder</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Steel</u>	11. BIRTHPLACE (State or foreign country) <u>Pennsylvania</u>
13. FATHER'S NAME <u>Thomas Morris</u>		14. MOTHER'S MAIDEN NAME <u>Alice Ritz</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> <u>XXXXX</u>		16. SOCIAL SECURITY No. <u>213-07-1042</u>	
		17. INFORMANT AND ADDRESS <u>Grace Morris Sparrows Pt. 19, Md.</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause

(a)

Coronary Occlusion

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS
PRIMARY ☐ OR CONTRIBUTING ☐
CAUSE OF DEATH.PLACE (Home, farm, factory, street, office bldg., etc.)
OF INJURY

(CITY OR TOWN)

(COUNTY)

20. AUTOPSY?

Yes ☐ No ☒ (STATE)TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at. Not while
work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

March 23-55Dawson L. HarberWalter Branches Bradley, Inc.Dundalk 22Maryland

MARGIN RESERVED FOR BINDING

VS. A15A

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 28 1935

RECEIVED

2427

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

112409

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>TOWSON</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Codd Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>2903 E. Baltimore St.</u>	
3. NAME OF DECEASED (Type or Print) <u>JOSEPH</u>	(First) <u>H.</u> (Middle)	(Last) <u>MULLEN SR.</u>	4. DATE OF DEATH <u>MARCH 25</u> 19 <u>55</u>
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH <u>Sept. 27, 1873</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tugboat Captain (Retired)</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>81</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Gregory Mullen</u>		14. MOTHER'S MAIDEN NAME <u>Mary Donnelly</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT <u>Herbert Mullen - 2822 E. Baltimore St.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X
Immediate cause(a) Cerebral arteriosclerosisAntecedent cause(s)
Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last(b) Generalized arteriosclerosis

(c)

INTERVAL BETWEEN
ONSET AND DEATHIndef.Indef.II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒
(STATE)

21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>HOMICIDE</u>	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from March 16, 1955 to March 25, 1955, that I last saw the deceasedalive on March 22, 1955, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Maddeus C. Swinski M.D. 17 W. Penna. Ave. Towson 4 Ind. March 25, 1955

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Mar. 28, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Sacred Heart Cemetery</u>	LOCATION (City, town, or county) <u>Baltimore, Md</u>	(State)
DATE REC'D BY LOCAL REG. <u>MAR 28 1955</u>	REGISTRAR'S SIGNATURE <u>Mark Gray</u>	24. FUNERAL DIRECTOR <u>John A. Moran</u>	ADDRESS <u>3000 E. Baltimore St.</u>	

per MM Moran

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 30 1955

RECEIVED

2428

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u>		55	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6614 Loch Raven Blvd.</u>				STREET ADDRESS (If rural give location) <u>6614 Loch Raven Blvd.</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <u>JOHN ARCHER MURRAY, JR.</u>				4. DATE OF DEATH: (Month) (Day) (Year) <u>March 10, 19 55</u>			
5. SEX: <u>Male</u>	5. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>July 27, 1917</u>	9. AGE last birthday: <u>37</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>Attendant</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Service Station</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>John Archer Murray</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Hiser</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY No.: <u>212-18-7900</u>		17. INFORMANT & ADDRESS: <u>John A. Murray, 6614 Loch Raven Blvd., Towson</u>			

18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>162x Immediate cause</u> (a) <u>Carcinoma, Bronchogenic (Squamous)</u> DUE TO Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>None</u> DUE TO (c)						Interval Between Onset And Death <u>6 months</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 1954</u> , to <u>10 Mch 1955</u> , that I last saw the deceased alive on <u>10 Mch 1955</u> , and that death occurred at <u>1 AM</u> , from the causes and on the date stated above. SIGNATURE <u>Charles A. Kers</u> (Degree or title) <u>M.D.</u> ADDRESS <u>6701 York Rd Balto Md</u> DATE SIGNED <u>11 Mch 55</u>							
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Mar. 12, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Mar. 12, 1955</u>		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>		24. FUNERAL DIRECTOR <u>John Burns Sons</u>		ADDRESS <u>Towson, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 14 1955
BUREAU V. S.

2429

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY BALTIMORE		MARYLAND		STATE MARYLAND COUNTY BALTIMORE			
CITY (If outside corporate limits, write RURAL OR and give nearest town) 55 TOWSON 4		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN 55 TOWSON 4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00 821 WELLINGTON RD.				STREET ADDRESS (If rural give location) 1 821 WELLINGTON ROAD			
3. NAME OF DECEASED: (First) (Middle) (Last) JOSEPH HOWARD MURRAY				4. DATE (Month) (Day) (Year) OF DEATH: MAR. 18, 1955			
5. SEX: MALE	6. COLOR OR RACE: WHITE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH: AUG. 2, 1898	9. AGE last birthday 56 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CHIEF JUDGE		10B. KIND OF BUSINESS OR INDUSTRY: CIRCUIT COURT		11. BIRTHPLACE (State or foreign country): MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME: JOSEPH B. MURRAY				14. MOTHER'S MAIDEN NAME: HELEN MURRAY			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT & ADDRESS: FAMILY RECORDS			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) 420.1 Congestive Heart Failure						13 months	
ANTECEDENT CAUSE (S) DUE TO (B) Old Rheumatic & Coronary disease						10 yrs	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Ventricular Fibrillation							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1946 , to Mar. , 19 55 . That I last saw the deceased alive on 3/11 , 19 55 , and that death occurred at 8 45 P.M. , from the causes and on the date stated above.							
SIGNATURE Not A. Sealback		ADDRESS M. D. 200 W. Penna. Ave Towson		DATE SIGNED 3/21/55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF MAR. 21, 1955		NAME OF CEMETERY OR CREMATORY PROSPECT HILL CEM. TOWSON, MD.		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR Mar. 21, 1955		REGISTRAR'S SIGNATURE Mabel C. Gray		4. JUNE 2 DIRECTOR John Burke Love, Towson, Md.		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 22 1955

BUREAU V. S.

2430

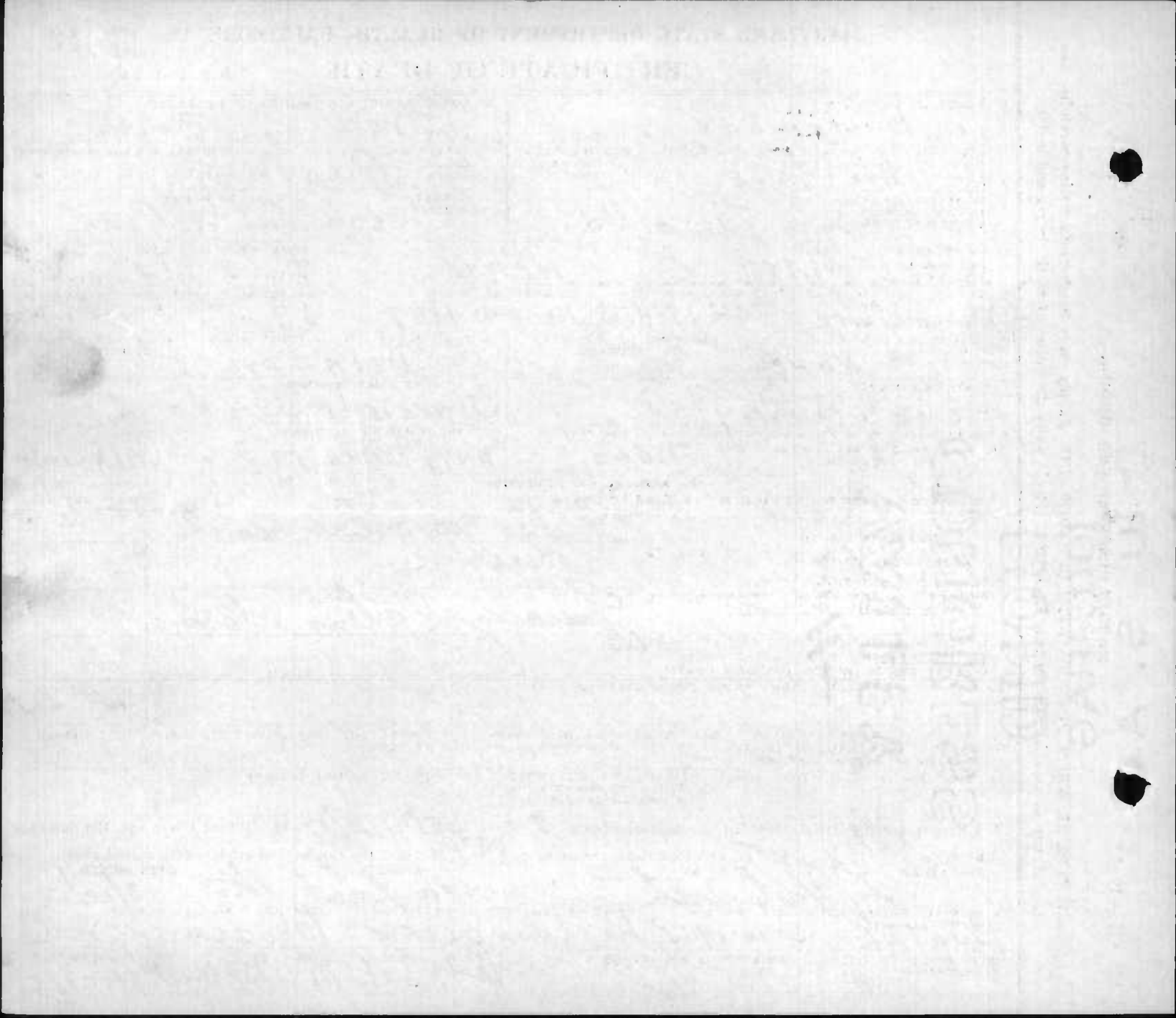
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>ROCKDALE</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>ROCKDALE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>3604 TULSA RD</u>				STREET ADDRESS (If rural give location) <u>3604 TULSA ROAD</u>			
3. NAME OF DECEASED: (First) <u>MARY</u> (Middle) <u>E.</u> (Last) <u>NEAL</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>9</u> <u>13</u> <u>1955</u>			
5. SEX: <u>FEMALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOW</u>	8. DATE OF BIRTH: <u>12-24-1867</u>	9. AGE last birthday: <u>87</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.		IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>GEROME H. B. DAYTON</u>				14. MOTHER'S MAIDEN NAME: <u>HARRIETT CANNON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS: <u>MARY H. MORITZ 306 S. CALHOUN ST</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE (A) <u>Cardiovascular renal disease</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE (S) (B) <u>Generalized arterio sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7/1</u> , 19 <u>55</u> to <u>2/13</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/12</u> , 19 <u>55</u> , and that death occurred at <u>830 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		ADDRESS <u>4710 Liberty St</u>		DATE SIGNED <u>3/15/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-16-1955</u>		NAME OF CEMETERY OR CREMATORY <u>HORRAINE @ EM</u>		LOCATION (City, town, or county) (State) <u>WOODLAWN MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/14/55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Porter B. M. Walters</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02414

2432

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Overlea</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Overlea</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8 East Overlea Avenue</u>				STREET ADDRESS (If rural give location) <u>8 East Overlea Avenue #6</u>			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>Mr. John Henry Nolker</u>				OF DEATH: <u>MARCH 10th 1955</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>male</u>	<u>white</u>	<u>married</u>	<u>Aug. 1, 1886</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Retired Capt. Balto City Fire Dept.</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME: <u>Henry Nolker</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Kramer</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
				17. INFORMANT & ADDRESS: <u>Mrs. Mary E. Nolker, 8 E. Overlea Ave. #6</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Congestive failure</u>							<u>2 days</u>
DUE TO							
ANTECEDENT CAUSE (B) <u>Coronary artery disease</u>							<u>?</u>
DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>arteriosclerotic</u>							<u>?</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>chr. cholecystitis + stones</u>							<u>3-4 yrs.</u>
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>18 March, 1954</u> , to <u>10 March, 1955</u> , that I last saw the deceased alive on <u>10 March</u> , 1955, and that death occurred at <u>5:47 P.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Samuel Lieber</u>				ADDRESS <u>7148 Preston St.</u>		DATE SIGNED <u>11 March 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 15, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-11-55</u>		REGISTRAR'S SIGNATURE <u>R W Adair</u>		24. FUNERAL DIRECTOR <u>Leonard J. Ruck, 5305 Harford Road #14</u>		ADDRESS	

Dr. Lilienfeld
714 E. Preston Street

6 - 8 Thursday

9 - 10 Friday.

2431

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Hampstead Rural</u>		<u>10 yrs</u>		OR TOWN <u>Hampstead Rural</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Upper Brehmerville Rd</u>				STREET ADDRESS (If rural, give location) <u>Upper Brehmerville Rd</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Gladie M. Netter</u>				<u>March 28 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH: <u>March 11 1909</u>	
						9. AGE last birthday: <u>48</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Home</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME: <u>James J. Lambert</u>				14. MOTHER'S MAIDEN NAME: <u>Lucie Albarr</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <u>217-01-6465</u>		17. INFORMANT & ADDRESS: <u>Andrew Netter Jr. Hampstead Md</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
153X Immediate cause (a) <u>Generalized Carcinomatosis</u>						<u>6 mo</u>	
Antecedent cause(s) (b) <u>Primary Carcinoma of Cervix</u>						<u>2 yrs.</u>	
(c)							
II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>Aug 1953</u>				19b. MAJOR FINDINGS OF OPERATION: <u>Primary Carcinoma of Cervix</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, or office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		HOMICIDE					
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
OF INJURY		M.					
22. I hereby certify that I attended the deceased from <u>Aug 1953</u> to <u>March 28 1955</u> , that I last saw the deceased alive on <u>March 26</u> , 19 <u>55</u> , and that death occurred at <u>12:45</u> p.m., from the causes and on the date stated above.							
SIGNATURE <u>Joseph E. Bush</u>				(DEGREE OR TITLE) <u>MD</u>		ADDRESS <u>Hampstead Md</u>	
23. BURIAL, CREMATION REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>Mar 31 55</u>		NAME OF CEMETERY OR CREMATORY: <u>Grave Run</u>		LOCATION (City, town, or county) <u>Baltimore Md</u>	
DATE REC'D BY LOCAL REG. <u>3-30-55</u>		REGISTRAR'S SIGNATURE <u>Mary B. Zline</u>		24. FUNERAL DIRECTOR <u>Edw. C. Ripston</u>		ADDRESS <u>Hampstead Md</u>	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

APR 1 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2433 CERTIFICATE OF DEATH

02415
65

Reg. Dist. No.....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>md</i> COUNTY <i>Balt.</i>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Essex</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cesary</i>		<i>54</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>				STREET ADDRESS (If rural, give location) <i>209 Eastern Blvd.</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>William Frederick Norton</i>				4. DATE OF DEATH: (Month) (Day) (Year) <i>3-28-1955</i>			
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <i>married</i>	8. DATE OF BIRTH: <i>2-16-1910</i>	9. AGE last birthday: <i>45</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Painter</i>				10b. KIND OF BUSINESS OR INDUSTRY: <i>Self Employed</i>		11. BIRTHPLACE (State or foreign country): <i>Georgia</i>	
13. FATHER'S NAME: <i>Fred. W. Norton</i>				12. CITIZEN OF WHAT COUNTRY? <i>United States</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY No.: <i>213-07-4269</i>		17. INFORMANT & ADDRESS: <i>Sarah Eliz. Norton (Wife) Above</i>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
416X Immediate cause	(a) DUE TO <i>Coronary Occlusion</i>	<i>instant</i>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	(b) DUE TO <i>Rheumatic Heart Disease</i>	<i>6 yrs</i>
(c)		

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

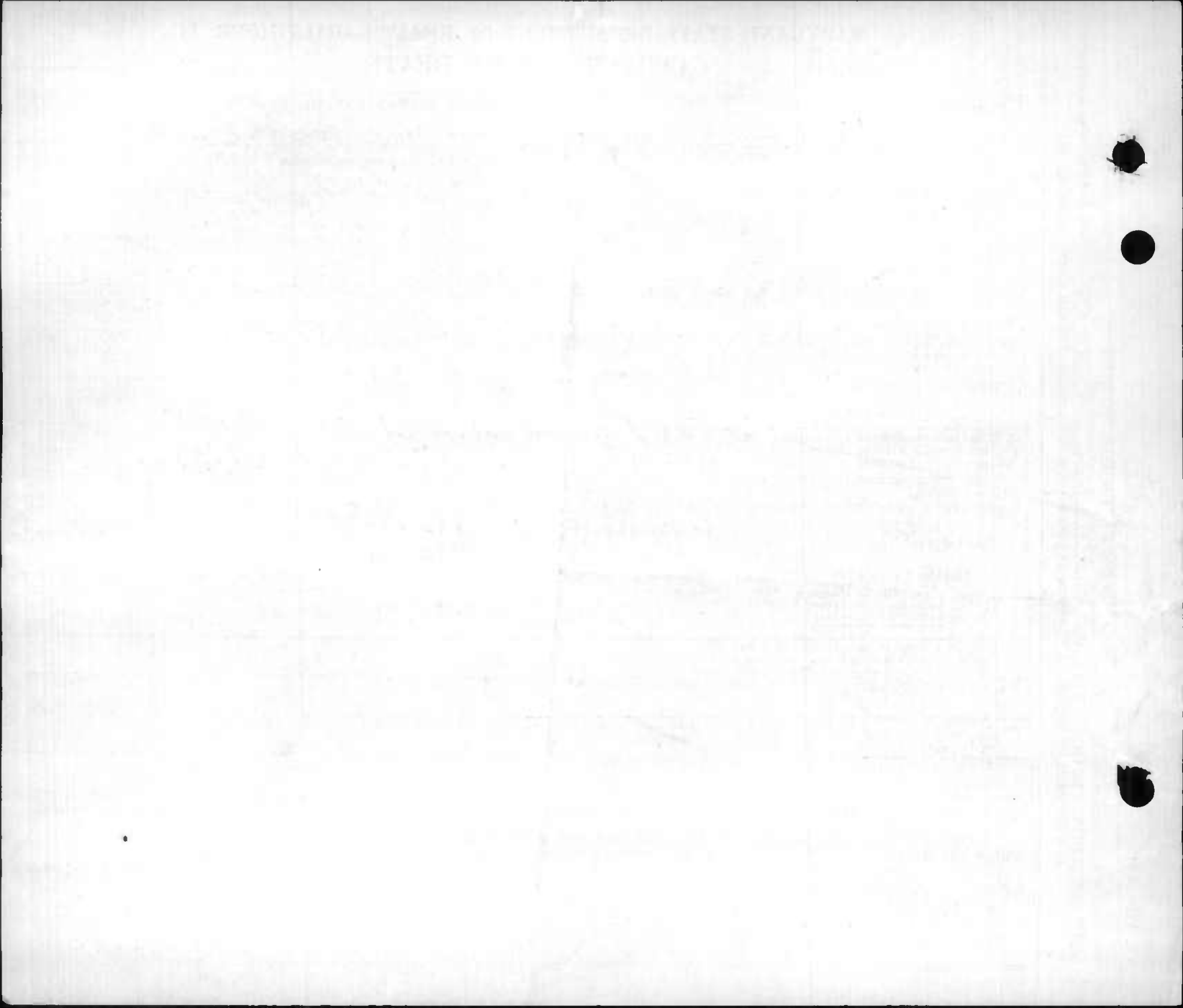
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE	(Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from *March 19, 1955* to *March 28, 1955*, that I last saw the deceased alive on *Jan 15, 1955*, and that death occurred at *3:35 P* m., from the causes and on the date stated above.

SIGNATURE <i>Joseph Meale</i>		(DEGREE OR TITLE) ADDRESS <i>423 Eastern Ave Md</i>		DATE SIGNED <i>3/29/55</i>	
23. BURIAL, CREMATION REMOVAL (Specify): <i>Burial</i>	DATE THEREOF <i>4-1-55</i>	NAME OF CEMETERY OR CREMATORY <i>Gunton Cemetery</i>		LOCATION (City, town, or county) (State) <i>Gunton Georgia</i>	
DATE REC'D BY LOCAL REG. <i>3-30-55</i>	REGISTRAR'S SIGNATURE <i>W. H. Hedrick</i>	24. FUNERAL DIRECTOR <i>John S. Connelley</i>		ADDRESS <i>Cesary</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2434

CERTIFICATE OF DEATH

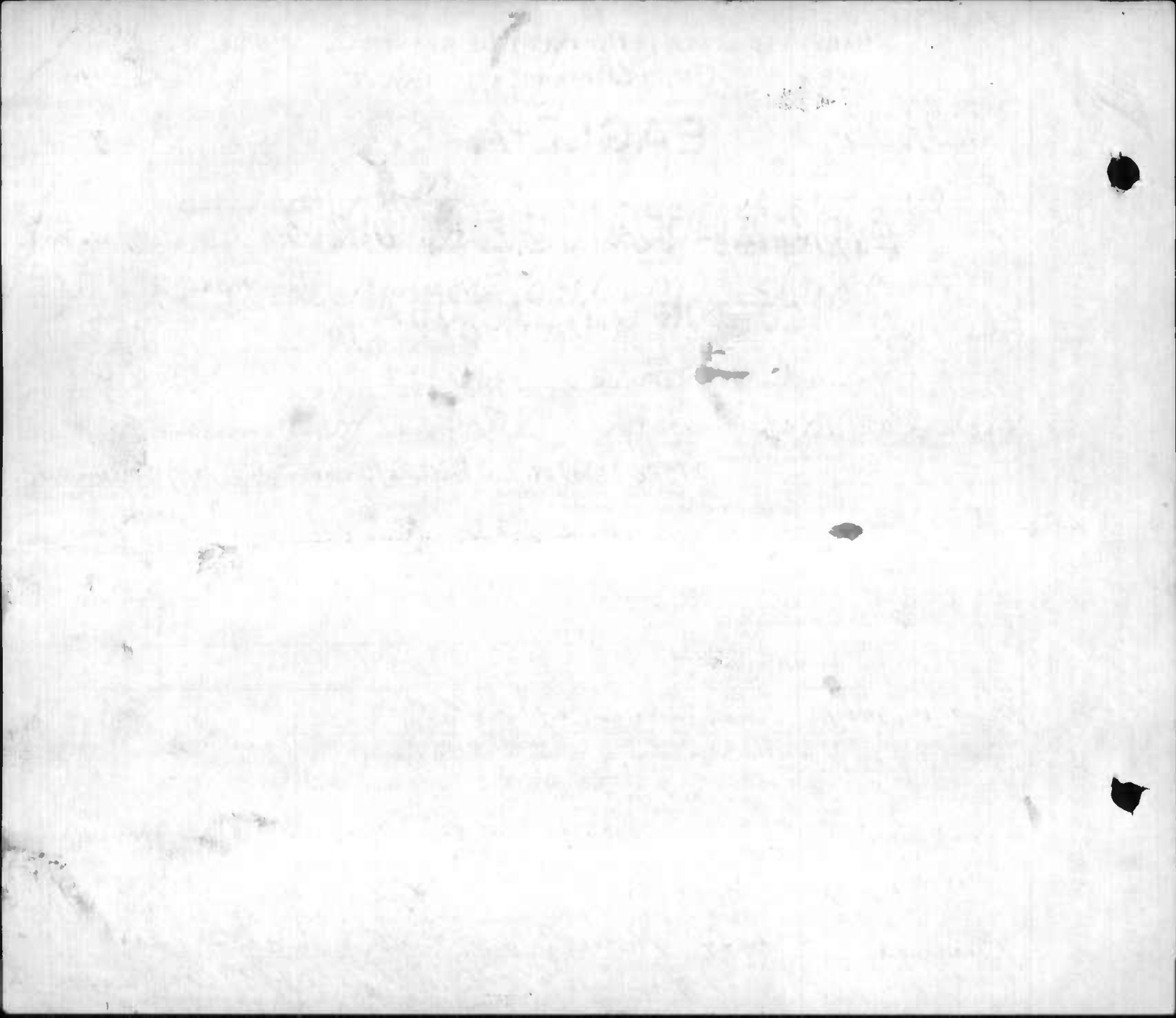
Reg. Dist. No. 45

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Balto.</i>	MARYLAND	STATE <i>md.</i>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>54 Middle River, Md.</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <i>3401-4 Balto.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00 19 Harrison Ave.</i>		STREET ADDRESS (If rural give location) <i>516 South Luzerne Ave, 24 Md.</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <i>Aniela</i> (Middle) <i>Macioch</i> (Last) <i>Oknaiski</i>		(Month) <i>Mar.</i> (Day) <i>3</i> (Year) <i>1955</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>W.</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>widowed</i>	8. DATE OF BIRTH: <i>Sept 17-1884</i>
9. AGE last birthday <i>70</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife - Retired</i>	
11. BIRTHPLACE (State or foreign country): <i>Poland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Nicholas Malinowski</i>		14. MOTHER'S MAIDEN NAME: <i>Teofila Malinski</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>215-03-20830A</i>	
17. INFORMANT & ADDRESS: <i>Christine Brudzinski - 1407 Eastern Ave.</i>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <i>Metastatic Carcinoma</i>		<i>6 mo</i>	
ANTECEDENT CAUSE (B) <i>Carcinoma of colon</i>		<i>18 mo</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>Sept 14, 1954</i>		19B. MAJOR FINDINGS OF OPERATION: <i>Carcinoma of colon</i>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June 15, 55</i> , to <i>Mar 3, 55</i> , that I last saw the deceased alive on <i>Mar 2, 1955</i> , and that death occurred at <i>10:10 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Joseph Macioch</i>		DATE SIGNED <i>Mar 3/55</i>	
M.D. <i>423 Eastern Ave</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>3-7-55</i>	
NAME OF CEMETERY OR CREMATORY <i>Holy Rosary Cemetery</i>		LOCATION (City, town, or county) (State) <i>Balto Co</i>	
DATE REC'D BY LOCAL REGISTRAR <i>3-4-55</i>		REGISTRAR'S SIGNATURE <i>A W Hedberg</i>	
FUNERAL DIRECTOR <i>Brudzinski</i>		ADDRESS <i>1407 Eastern Ave</i>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02417

2435

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		10 Days		OR TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>3 Carroll Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
CHARLES A. OLIVER				March 18, 1955			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	Colored	Widowed	January 14, 1879	76 yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Building Attendant		Federal Government		Annapolis, Maryland		U. S. A.	
13. FATHER'S NAME: Arthur Oliver				14. MOTHER'S MAIDEN NAME: Rachel MN: Watkins			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				17. INFORMANT & ADDRESS:			
Yes <input checked="" type="checkbox"/> WW-I				Clin. Rec., Vet. Adm. Hospital, Fort Howard, Md.			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				UNKNOWN			
IMMEDIATE CAUSE (A) SENILITY AND DIABETES MELLITUS							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				2 DAYS			
19A. DATE OF OPERATION: 3-16-55				19B. MAJOR FINDINGS OF OPERATION			
Above Knee Amputation, Left leg				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
VA		M.					
22. I hereby certify that I attended the deceased from Mar. 8, 1955, to March 18, 1955, and that death occurred at 9:50 PM, from the causes and on the date stated above.							
SIGNATURE <u>William B. Vandegrift, M.D.</u>				ADDRESS <u>M. D. VAH, Fort Howard, Md.</u>			
DATE SIGNED <u>3-19-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		3/22/1955		Annapolis National Cem.		Annapolis, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
March 21, 1955		<u>Lawson L. Farley</u>		Ethel Hicks Funeral Home, 43-45 Northwest Street, Annapolis, Maryland			

BUREAU V. S.

MAR 21 1955

RECEIVED

02418

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2436

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u>		LENGTH OF STAY (In this place) <u>2 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1822 N. Register St.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>WESLEY</u> <u>PAYNE</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>March</u> <u>10</u> <u>1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Negro</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>11/25/87</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Construction</u>		11. BIRTHPLACE (State or foreign country): <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW I</u>			16. SOCIAL SECURITY NO. <u>212-12-1966</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>		
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>CEREBRO-VASCULAR ACCIDENT</u>						10 DAYS	
ANTECEDENT CAUSE (B) <u>DUE TO HYPERTENSION, ESSENTIAL</u>						UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. <u>DUE TO ARTERIOSCLEROSIS</u>						UNKNOWN	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>LUES PNEUMONITIS</u>						TERMINAL	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> <u>M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Mar. 8, 1955</u> , to <u>Mar. 10, 1955</u> , and that death occurred at <u>5:45 PM</u> , from the causes and on the date stated above. SIGNATURE <u>Francis G. Dickey</u> ADDRESS <u>D. VAH, Fort Howard, Md.</u> DATE SIGNED <u>3-11-55</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-15-55</u>		REGISTRAR'S SIGNATURE <u>A. H. Hedrick</u>		24. FUNERAL DIRECTOR <u>Rayner Sanders Funeral Home</u> ADDRESS <u>217 E. Preston Street, Baltimore, Md.</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAILED AND STATE DEPARTMENT OF JUSTICE
COMMUNICATIONS SECTION
JAN 10 1964
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535
TO : DIRECTOR, FBI
FROM : SAC, NEW YORK
SUBJECT: [Illegible]
RE: [Illegible]
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a teletype or memorandum. The text is mirrored across the page, suggesting a bleed-through from the reverse side.]

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02419

2437

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Mass.</i> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <i>Cockeysville Md</i>		<i>2 yrs</i>		TOWN <i>Pittsfield Mass.</i>		<i>58X-3</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>90 Masonic Home</i>				STREET ADDRESS (If rural give location) <i>Narragansett Ave</i>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<i>William Redgrove Perine</i>				<i>Mar. 29 1955</i>			
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: <i>Jan. 9-1865</i>	
						9. AGE last birthday: <i>90</i> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Night Watchman</i>				10B. KIND OF BUSINESS OR INDUSTRY: <i>Permon & Klein</i>		11. BIRTHPLACE (State or foreign country): <i>Baltimore Md</i>	
12. FATHER'S NAME: <i>Wm. H. Perine</i>				13. MOTHER'S MAIDEN NAME: <i>Emma C. Evans</i>			
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.):				15. SOCIAL SECURITY No. <i>212-16-04562</i>		16. INFORMANT & ADDRESS: <i>Laura M. Schroeder</i>	
17. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>443X</i>				<i>over 2 yrs</i>			
ANTECEDENT CAUSE (S) <i>Hypertensive Arterio sclerosis</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <i>Vascular disease</i>							
(C) <i>and Bronchitis</i>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>4-8-1953</i> , to <i>Mar. 29, 1955</i> , that I last saw the deceased alive on <i>Mar. 29, 1955</i> , and that death occurred at <i>4:50 P. M.</i> from the causes and on the date stated above.							
SIGNATURE <i>Walter J. Kus</i>		ADDRESS <i>M. D. Cockeysville Md</i>		DATE SIGNED <i>30 March 1955</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>4/1/55</i>		NAME OF CEMETERY OR CREMATORY <i>Lorraine Cemetery</i>		LOCATION (City, town, or county) <i>Balto. Md</i>		(State)	
DATE REC'D BY LOCAL REGISTRAR <i>3/29/55</i>		REGISTRAR'S SIGNATURE <i>L.M. Schroeder</i>		24. FUNERAL DIRECTOR <i>Wm. Cook</i>		ADDRESS <i>St. Paul & Preston St</i>	

RECEIVED
APR 1 1955
BUREAU V. S.

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WRITE WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.

Every item of information should be carefully supplied. Physicians: please write the causes of death clearly and legibly. THIS CERTIFICATE MUST BE FILED WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER DE

STATE OF MARYLAND		CERTIFICATE OF DEATH		Registered No. 02420	
BIRTH NO. 2438		1. NAME OF DECEASED (Type or Print) Josephine E. Peters		2. DATE OF DEATH 3/7/53	
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore Co.		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY			
B. FULL NAME OF (If not in hospital or institution, give street address or location) Daughters of the (Catholic) Eucharist Home 90 52		C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Baltimore 3401-4		D. STREET ADDRESS (If rural, give location) 1124 Scott St.	
C. Length of stay in Baltimore Life		5. SEX Female		6. COLOR OR RACE white	
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH 1/2/1881		9. AGE (In years last birthday) 74	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10B. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Baltimore	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John M. Neubert		14. MOTHER'S MAIDEN NAME Anna Lambert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Marie C. B. Lottenberger	
18. 420.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) arteriosclerotic Heart Disease		unknown	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (260X)		(B) coronary occlusion		1 Hour	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.		Diabetes mellitus		unknown	
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (NOTIFY MEDICAL EXAMINER)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from March 15 1952 to March 7 1953, that (I) (we) last saw the deceased alive on March 6 1953, and that death occurred at 1:45 A.M., from the causes and on the date stated above.		23A. SIGNATURE Nathan Roemer M.D. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23B. ADDRESS 206 S. Gilman St.		23C. DATE SIGNED 3-7-53		24A. BURIAL, CREMATION, REMOVAL (Specify) Burial	
24B. DATE 3/10/53		24C. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		24D. LOCATION (City, town, or county) (State) 4360 Old Frederick Rd. Baltimore	
DATE RECEIVED BY LOCAL REGISTRAR 3-7-53		REGISTRAR'S SIGNATURE [Signature]		25. FUNERAL DIRECTOR John J. Bowman & Son	
VS 150		ADDRESS [Address]			

1. NAME OF DECEASED		2. DATE OF DEATH		3. PLACE OF DEATH		4. CAUSE OF DEATH		5. MANNER OF DEATH		6. SEX		7. AGE		8. OCCUPATION		9. EDUCATION		10. RELIGION		11. MARITAL STATUS		12. SOCIAL STATUS		13. ETHNIC ORIGIN		14. RACE		15. COLOR		16. HEIGHT		17. WEIGHT		18. HAIR		19. EYES		20. SKIN		21. BIRTH DATE		22. BIRTH PLACE		23. BIRTH TIME		24. BIRTH WEIGHT		25. BIRTH LENGTH		26. BIRTH HEAD CIRCUMFERENCE		27. BIRTH ARM CIRCUMFERENCE		28. BIRTH LEG CIRCUMFERENCE		29. BIRTH FOOT CIRCUMFERENCE		30. BIRTH FINGER CIRCUMFERENCE		31. BIRTH PALM CIRCUMFERENCE		32. BIRTH HEEL CIRCUMFERENCE		33. BIRTH ANKLE CIRCUMFERENCE		34. BIRTH WRIST CIRCUMFERENCE		35. BIRTH NECK CIRCUMFERENCE		36. BIRTH THORAX CIRCUMFERENCE		37. BIRTH ABDOMEN CIRCUMFERENCE		38. BIRTH PELVIS CIRCUMFERENCE		39. BIRTH HIP CIRCUMFERENCE		40. BIRTH BUTTOCK CIRCUMFERENCE		41. BIRTH CUFF CIRCUMFERENCE		42. BIRTH WRIST CIRCUMFERENCE		43. BIRTH NECK CIRCUMFERENCE		44. BIRTH THORAX CIRCUMFERENCE		45. BIRTH ABDOMEN CIRCUMFERENCE		46. BIRTH PELVIS CIRCUMFERENCE		47. BIRTH HIP CIRCUMFERENCE		48. BIRTH BUTTOCK CIRCUMFERENCE		49. BIRTH CUFF CIRCUMFERENCE		50. BIRTH WRIST CIRCUMFERENCE		51. BIRTH NECK CIRCUMFERENCE		52. BIRTH THORAX CIRCUMFERENCE		53. BIRTH ABDOMEN CIRCUMFERENCE		54. BIRTH PELVIS CIRCUMFERENCE		55. BIRTH HIP CIRCUMFERENCE		56. BIRTH BUTTOCK CIRCUMFERENCE		57. BIRTH CUFF CIRCUMFERENCE		58. BIRTH WRIST CIRCUMFERENCE		59. BIRTH NECK CIRCUMFERENCE		60. BIRTH THORAX CIRCUMFERENCE		61. BIRTH ABDOMEN CIRCUMFERENCE		62. BIRTH PELVIS CIRCUMFERENCE		63. BIRTH HIP CIRCUMFERENCE		64. BIRTH BUTTOCK CIRCUMFERENCE		65. BIRTH CUFF CIRCUMFERENCE		66. BIRTH WRIST CIRCUMFERENCE		67. BIRTH NECK CIRCUMFERENCE		68. BIRTH THORAX CIRCUMFERENCE		69. BIRTH ABDOMEN CIRCUMFERENCE		70. BIRTH PELVIS CIRCUMFERENCE		71. BIRTH HIP CIRCUMFERENCE		72. BIRTH BUTTOCK CIRCUMFERENCE		73. BIRTH CUFF CIRCUMFERENCE		74. BIRTH WRIST CIRCUMFERENCE		75. BIRTH NECK CIRCUMFERENCE		76. BIRTH THORAX CIRCUMFERENCE		77. BIRTH ABDOMEN CIRCUMFERENCE		78. BIRTH PELVIS CIRCUMFERENCE		79. BIRTH HIP CIRCUMFERENCE		80. BIRTH BUTTOCK CIRCUMFERENCE		81. BIRTH CUFF CIRCUMFERENCE		82. BIRTH WRIST CIRCUMFERENCE		83. BIRTH NECK CIRCUMFERENCE		84. BIRTH THORAX CIRCUMFERENCE		85. BIRTH ABDOMEN CIRCUMFERENCE		86. BIRTH PELVIS CIRCUMFERENCE		87. BIRTH HIP CIRCUMFERENCE		88. BIRTH BUTTOCK CIRCUMFERENCE		89. BIRTH CUFF CIRCUMFERENCE		90. BIRTH WRIST CIRCUMFERENCE		91. BIRTH NECK CIRCUMFERENCE		92. BIRTH THORAX CIRCUMFERENCE		93. BIRTH ABDOMEN CIRCUMFERENCE		94. BIRTH PELVIS CIRCUMFERENCE		95. BIRTH HIP CIRCUMFERENCE		96. BIRTH BUTTOCK CIRCUMFERENCE		97. BIRTH CUFF CIRCUMFERENCE		98. BIRTH WRIST CIRCUMFERENCE		99. BIRTH NECK CIRCUMFERENCE		100. BIRTH THORAX CIRCUMFERENCE		101. BIRTH ABDOMEN CIRCUMFERENCE		102. BIRTH PELVIS CIRCUMFERENCE		103. BIRTH HIP CIRCUMFERENCE		104. BIRTH BUTTOCK CIRCUMFERENCE		105. BIRTH CUFF CIRCUMFERENCE		106. BIRTH WRIST CIRCUMFERENCE		107. BIRTH NECK CIRCUMFERENCE		108. BIRTH THORAX CIRCUMFERENCE		109. BIRTH ABDOMEN CIRCUMFERENCE		110. BIRTH PELVIS CIRCUMFERENCE		111. BIRTH HIP CIRCUMFERENCE		112. BIRTH BUTTOCK CIRCUMFERENCE		113. BIRTH CUFF CIRCUMFERENCE		114. BIRTH WRIST CIRCUMFERENCE		115. BIRTH NECK CIRCUMFERENCE		116. BIRTH THORAX CIRCUMFERENCE		117. BIRTH ABDOMEN CIRCUMFERENCE		118. BIRTH PELVIS CIRCUMFERENCE		119. BIRTH HIP CIRCUMFERENCE		120. BIRTH BUTTOCK CIRCUMFERENCE		121. BIRTH CUFF CIRCUMFERENCE		122. BIRTH WRIST CIRCUMFERENCE		123. BIRTH NECK CIRCUMFERENCE		124. BIRTH THORAX CIRCUMFERENCE		125. BIRTH ABDOMEN CIRCUMFERENCE		126. BIRTH PELVIS CIRCUMFERENCE		127. BIRTH HIP CIRCUMFERENCE		128. BIRTH BUTTOCK CIRCUMFERENCE		129. BIRTH CUFF CIRCUMFERENCE		130. BIRTH WRIST CIRCUMFERENCE		131. BIRTH NECK CIRCUMFERENCE		132. BIRTH THORAX CIRCUMFERENCE		133. BIRTH ABDOMEN CIRCUMFERENCE		134. BIRTH PELVIS CIRCUMFERENCE		135. BIRTH HIP CIRCUMFERENCE		136. BIRTH BUTTOCK CIRCUMFERENCE		137. BIRTH CUFF CIRCUMFERENCE		138. BIRTH WRIST CIRCUMFERENCE		139. BIRTH NECK CIRCUMFERENCE		140. BIRTH THORAX CIRCUMFERENCE		141. BIRTH ABDOMEN CIRCUMFERENCE		142. BIRTH PELVIS CIRCUMFERENCE		143. BIRTH HIP CIRCUMFERENCE		144. BIRTH BUTTOCK CIRCUMFERENCE		145. BIRTH CUFF CIRCUMFERENCE		146. BIRTH WRIST CIRCUMFERENCE		147. BIRTH NECK CIRCUMFERENCE		148. BIRTH THORAX CIRCUMFERENCE		149. BIRTH ABDOMEN CIRCUMFERENCE		150. BIRTH PELVIS CIRCUMFERENCE		151. BIRTH HIP CIRCUMFERENCE		152. BIRTH BUTTOCK CIRCUMFERENCE		153. BIRTH CUFF CIRCUMFERENCE		154. BIRTH WRIST CIRCUMFERENCE		155. BIRTH NECK CIRCUMFERENCE		156. BIRTH THORAX CIRCUMFERENCE		157. BIRTH ABDOMEN CIRCUMFERENCE		158. BIRTH PELVIS CIRCUMFERENCE		159. BIRTH HIP CIRCUMFERENCE		160. BIRTH BUTTOCK CIRCUMFERENCE		161. BIRTH CUFF CIRCUMFERENCE		162. BIRTH WRIST CIRCUMFERENCE		163. BIRTH NECK CIRCUMFERENCE		164. BIRTH THORAX CIRCUMFERENCE		165. BIRTH ABDOMEN CIRCUMFERENCE		166. BIRTH PELVIS CIRCUMFERENCE		167. BIRTH HIP CIRCUMFERENCE		168. BIRTH BUTTOCK CIRCUMFERENCE		169. BIRTH CUFF CIRCUMFERENCE		170. BIRTH WRIST CIRCUMFERENCE		171. BIRTH NECK CIRCUMFERENCE		172. BIRTH THORAX CIRCUMFERENCE		173. BIRTH ABDOMEN CIRCUMFERENCE		174. BIRTH PELVIS CIRCUMFERENCE		175. BIRTH HIP CIRCUMFERENCE		176. BIRTH BUTTOCK CIRCUMFERENCE		177. BIRTH CUFF CIRCUMFERENCE		178. BIRTH WRIST CIRCUMFERENCE		179. BIRTH NECK CIRCUMFERENCE		180. BIRTH THORAX CIRCUMFERENCE		181. BIRTH ABDOMEN CIRCUMFERENCE		182. BIRTH PELVIS CIRCUMFERENCE		183. BIRTH HIP CIRCUMFERENCE		184. BIRTH BUTTOCK CIRCUMFERENCE		185. BIRTH CUFF CIRCUMFERENCE		186. BIRTH WRIST CIRCUMFERENCE		187. BIRTH NECK CIRCUMFERENCE		188. BIRTH THORAX CIRCUMFERENCE		189. BIRTH ABDOMEN CIRCUMFERENCE		190. BIRTH PELVIS CIRCUMFERENCE		191. BIRTH HIP CIRCUMFERENCE		192. BIRTH BUTTOCK CIRCUMFERENCE		193. BIRTH CUFF CIRCUMFERENCE		194. BIRTH WRIST CIRCUMFERENCE		195. BIRTH NECK CIRCUMFERENCE		196. BIRTH THORAX CIRCUMFERENCE		197. BIRTH ABDOMEN CIRCUMFERENCE		198. BIRTH PELVIS CIRCUMFERENCE		199. BIRTH HIP CIRCUMFERENCE		200. BIRTH BUTTOCK CIRCUMFERENCE		201. BIRTH CUFF CIRCUMFERENCE		202. BIRTH WRIST CIRCUMFERENCE		203. BIRTH NECK CIRCUMFERENCE		204. BIRTH THORAX CIRCUMFERENCE		205.	
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2439

Item 9. Film 180 4-27-55 et

02421

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 37

1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Pikesville
 TOWN Pikesville
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Park Heights Avenue

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Anne Arundel
 CITY (If outside corporate limits write RURAL and give nearest town) Lothian
 TOWN Lothian
 STREET ADDRESS (If rural, give location) 02X-2

3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE OF DEATH

(Month)

(Day)

(Year)

5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH:

9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

Female
 Colored
 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY:
Married

26 1/2 yrs.
 7-7-28
 Lothian, Md

3 27 1955
 Months Days Hours Min.
 USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
No

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

John Parker Harwood, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) DUE TO

Fracture dislocation of 4th cervical vertebra,

Antecedent cause(s)

(b) DUE TO

Crushed chest,

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(c)

Comminuted fracture of pelvis, Comminuted fracture of right femur.

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING CAUSE OF DEATH.21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Street

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY 3/27/55 11:50AM

21e. INJURY OCCURRED While at work ☐ Not while at work ☒

21f. HOW DID INJURY OCCUR?

Auto ran off road, struck utility pole.

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

William Reese

M. D.

CHIEF MEDICAL EXAMINER
 DEPUTY MEDICAL EXAMINER
 ASSISTANT MEDICAL EXAM.

DATE SIGNED

3/28/55

23. BURIAL, CREMATION, REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG. 3-29-55

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

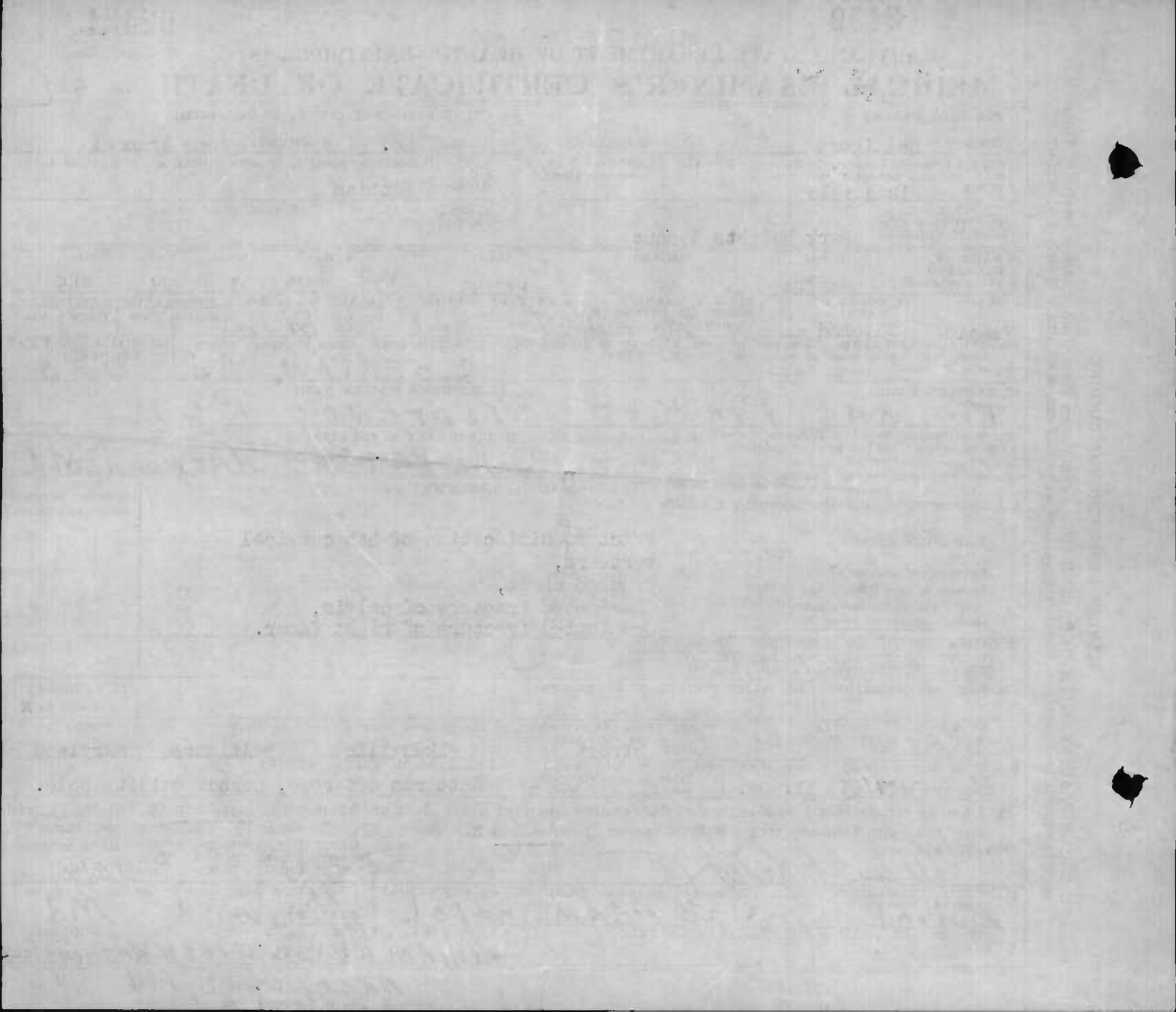
William Reese 108 W. Washington

Annapolis, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK—Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02422

2440
CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) Fort Howard		LENGTH OF STAY (in this place) 24 Hrs. 30 Min		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Veterans Administration Hospital				STREET ADDRESS (If rural give location) 3525 Hickory Avenue			
3. NAME OF DECEASED: (First) (Middle) (Last) JOHN FRANK PETTIS				4. DATE (Month) (Day) (Year) OF DEATH: March 6 1955			
5. SEX: Male	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED: (separated) Married	8. DATE OF BIRTH: March 4, 1893	9. AGE last birthday 62 yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Baker		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): Washington, D. C.		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME: William Pettis				14. MOTHER'S MAIDEN NAME: Annie MN: Dipper			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) Yes WW-I		16. SOCIAL SECURITY NO. 212-14-9270		17. INFORMANT & ADDRESS: Clin. Rec., Vet. Adm. Hosp. Fort Howard, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE 162X							
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						2 YEARS	
(A) BRONCHOGENIC CARCINOMA, RIGHT UPPER LOBE							
XXX WITH METASTASES TO LEFT HUMERUS, LEFT							
XXX FEMUR AND LYMPH NODES							
(B) PATHOLOGIC FRACTURE OF LEFT FEMUR						Approx. 36 HOURS	
XXX Due To METASTASIS FROM BRONCHOGENIC CARCINOMA							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. ARTERIOSCLEROSIS, GENERALIZED							
19A. DATE OF OPERATION: 3-5-55		19B. MAJOR FINDINGS OF OPERATION Insertion of Kirschner wire into left tibia for traction purposes for pathologic fracture left femur				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY VA		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from March 5, 1955 , to March 6, 1955 , that between the deceased and that death occurred at 7:30 PM , from the causes and on the date stated above.							
SIGNATURE Joseph M. Miller		ADDRESS		DATE SIGNED			
JOSEPH M. MILLER, M.D. Chief, Surgical Service D. VAH, Fort Howard, Maryland		3-7-55					
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3-9-55		NAME OF CEMETERY OR CREMATORY Baltimore National		LOCATION (City, town, or county) (State) Baltimore, Maryland	
DATE REC'D BY LOCAL REGISTRAR 3-8-55		REGISTRAR'S SIGNATURE A W Hedman		24. FUNERAL DIRECTOR Wm. Ticker & Sons Funeral Home		ADDRESS Penna. Ave. & North Ave., Baltimore, Md.	

THE STATE OF NEW YORK
IN SENATE
January 10, 1907.
REPORT
OF THE
COMMISSIONERS OF THE LAND OFFICE
IN RESPONSE TO A RESOLUTION
PASSED BY THE SENATE
MAY 1, 1906.
ALBANY:
J. B. LEECH, STATE PRINTER.
1907.

RECEIVED JAN 11 1907

RECEIVED JAN 11 1907

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 43

2441

02423

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Raspeburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>	
TOWN <u>Raspeburg</u>		TOWN <u>Raspeburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7939 Belair Rd.</u>		STREET ADDRESS (If rural, give location) <u>7939 Belair Rd.</u>	
3. NAME OF DECEASED (First) <u>Alma</u> (Middle) <u>B</u> (Last) <u>Pielke</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>1</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Sept. 24, 1894</u>
9. AGE last birthday <u>80</u> yrs.		10. AGE last birthday If under 1 year If under 24 hrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ferdinand Blechstein</u>		14. MOTHER'S MAIDEN NAME <u>Gervan</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr. Gerald Pielke 7939 Belair Rd. Balt. Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Myocardial Infarction</u>		<u>minutes</u>	
Antecedent cause(s) (b) <u>Chronic Cardiac Failure</u>		<u>several years</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Arteriosclerotic Cardiovascular Disease</u>		<u>many years</u>	
II. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death. <u>Degenerative myocardial changes</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1 Jan.</u> , 19 <u>55</u> , to <u>1 Mar.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>28 Feb.</u> , 19 <u>55</u> , and that death occurred at <u>6 AM</u> m., from the causes and on the date stated above.			
SIGNATURE: <u>John C. Hyle MD</u>		ADDRESS: <u>7527 Belair Rd Balto Md</u> DATE SIGNED: <u>3-3-55</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	
<u>Burial</u>		<u>3/3/55</u>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Parthwood</u>		<u>Balto. City Md.</u>	
DATE REC'D BY LOCAL REG.		24. FUNERAL DIRECTOR	
<u>Mar 3-1955</u>		<u>Passan Funeral Home</u>	
REGISTRAR'S SIGNATURE		ADDRESS	
<u>John C. Hyle MD</u>		<u>7401 Belair Rd.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Hyle
13clair Rd.

BUREAU V. S.

MAR 7 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH
2442 **CERTIFICATE OF DEATH**
 FOR MEDICAL EXAMINERS

02424

Reg. Dist. No. **35-**

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - Parkton</u> LENGTH OF STAY (to this place) <u>2 min.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural - White Hall</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>York Rd.</u>		STREET ADDRESS (If rural, give location) <u>Wiseburg Rd.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charles</u> (Middle) <u>A.</u> (Last) <u>Pisani</u>	4. DATE OF DEATH	(Month) <u>MAY</u> (Day) <u>12</u> (Year) <u>1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>July 1, 1919</u>
9. AGE last birthday <u>35</u> yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane Operator</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>
12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	13. FATHER'S NAME <u>A. L. Pisani</u>	14. MOTHER'S MAIDEN NAME <u>Ruth A. Henry</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes.</u>
16. SOCIAL SECURITY No. <u>218-10-4350</u>	17. INFORMANT AND ADDRESS <u>A. L. Pisani - White Hall, Md.</u>	18. MEDICAL CERTIFICATION	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
(a) <u>821X</u> Immediate cause <u>MULTIPLE Compound fracture of the skull</u>		<u>Instant</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.	PLACE (Home, farm, factory, street, or office bldg., etc.) INJURY <u>Route 111</u>	(CITY OR TOWN) <u>Parkton Ind.</u> (COUNTY) <u>03</u> (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>MAY 12 1955 11:45 am.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Thrown off motorcycle</u>
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .		
SIGNATURE <u>A. M. France M.D.</u>		DATE SIGNED <u>3/13/55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>March 15 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Wiseburg Cemetery</u>
LOCATION (City, town, or county) <u>White Hall, Balto. Co., Md.</u>	24. FUNERAL DIRECTOR <u>Jacob Hartenstein, New Freedom, Pa.</u>	ADDRESS <u>White Hall, Balto. Co., Md.</u>
DATE REC'D BY LOCAL REG. <u>Mar 14 1955</u>	REGISTRAR'S SIGNATURE <u>Charles E. Sullivan</u>	

RECEIVED

MAR 24 1965

BUREAU V. S.

2443

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH FOR MEDICAL EXAMINERS

02425

Reg. Dist. No. 44

1. PLACE OF DEATH- COUNTY <u>BALTO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sparrows Pt.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Beth. Steel Disp.</u>		STREET ADDRESS <u>704 "J" St.</u>	
3. NAME OF DECEASED (Type or Print) <u>ERNEST</u>	(First)	(Middle)	(Last) <u>Pleasant.</u>
4. SEX <u>M</u>	5. COLOR OR RACE <u>Black</u>	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	7. DATE OF BIRTH <u>9-10-34</u>
8. AGE last birthday <u>70</u> yrs.	9. DATE OF DEATH <u>3-5-55</u>	10. If under 1 year Months Days	11. If under 24 hrs. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Steelworker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Bethlehem Steel</u>	
11. BIRTHPLACE (State or foreign country) <u>Clarksville, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>216-10-4224</u>	
17. INFORMANT AND ADDRESS <u>Mr. Lester Pleasant 2706 Large Farm Rd.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) 840X Fractures - Compound - of Rt Tibia & Fibula - Left Femur - Fracture of pelvis, Rt hip
 (b) lower ribs - 3 INTERNAL INJURIES

Antecedent cause(s)
 Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing in the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office, etc.) OF INJURY Street

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY 3-5-55 10 a.m.INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR

Struck by Balt. Trans Street Car

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

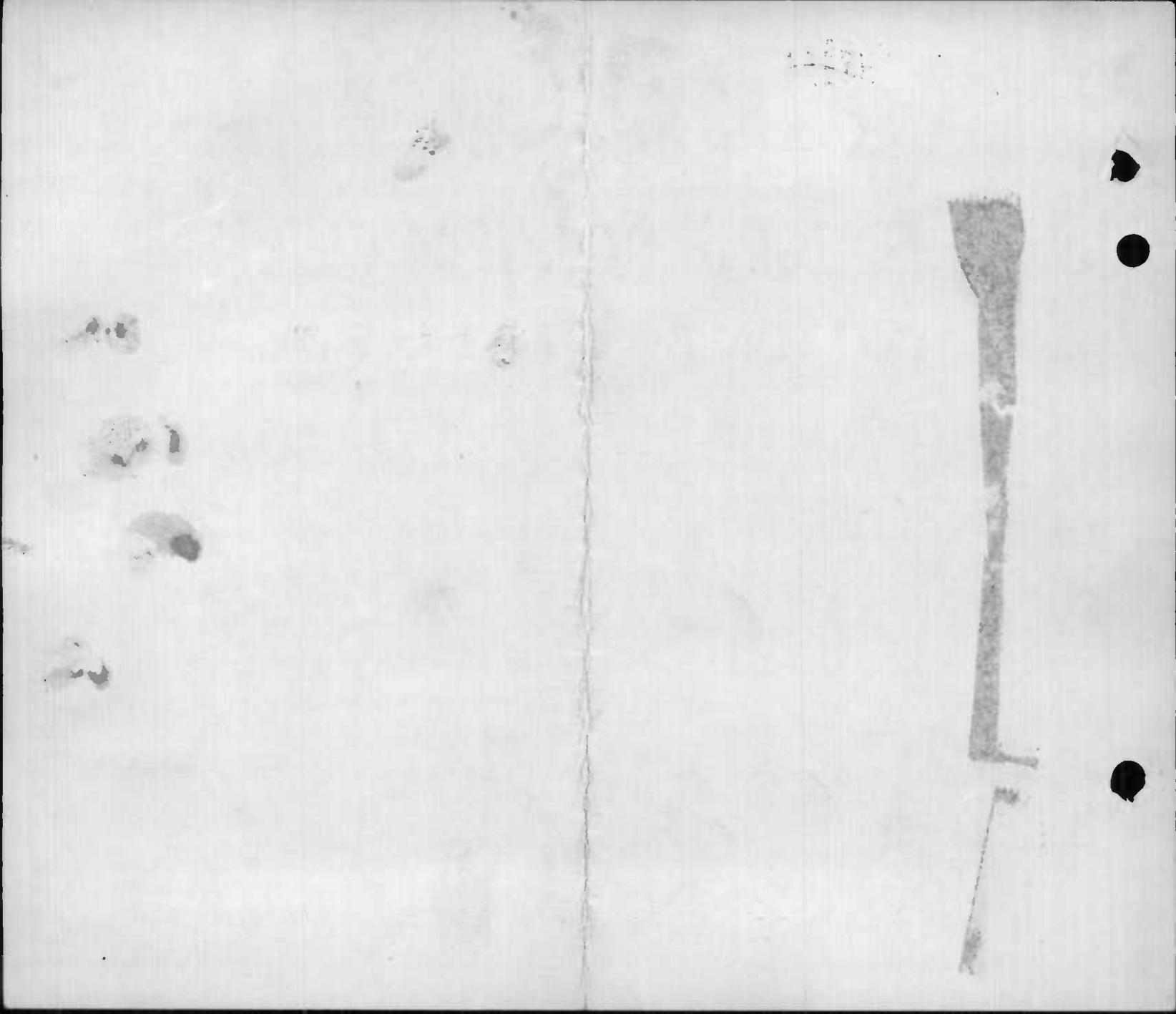
24. FUNERAL DIRECTOR

ADDRESS

3-7-55Charles R. LawCharles R. Law802 Madison Ave.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2446

02426

Reg. Dist. 45

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND				STATE <u>md.</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>ESSEX</u>				CITY (If outside corporate limits write RURAL and give nearest town) <u>Baltimore</u> <u>3401-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Back River</u>				STREET ADDRESS (If rural, give location) <u>3108 Woodring Av.</u>			
3. NAME OF DECEASED:		(First) <u>GEORGE</u>		(Middle)		(Last) <u>POLITES</u>	
(Type or Print)						4. DATE OF DEATH <u>3-12-55</u> <u>10-</u>	
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>MARRIED</u>	8. DATE OF BIRTH:		9. AGE last birthday: <u>64</u> yrs.	IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Butcher</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Grocery</u>		11. BIRTHPLACE (State or foreign country): <u>Greece</u>		12. CITIZEN OF WHAT COUNTRY? <u>Greece</u> ✓	
13. FATHER'S NAME: <u>Matthew</u>				14. MOTHER'S MAIDEN NAME: <u>unk</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>212-34-4694</u>		17. INFORMANT & ADDRESS: <u>Son - Same</u>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>DROWNING</u> DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>river</u>		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
				<u>Balto.</u>		<u>Md.</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>3/11/55</u> <u>M.</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>Apparently jumped in river</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>R. W. Fisher</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>3-12-55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3-15-55</u>		NAME OF CEMETERY OR CREMATORY <u>Greek Cemetery</u>		LOCATION (City, town, or county) (State) <u>Windsor Mill Rd.</u>	
DATE REC'D BY LOCAL REG. <u>3/14/55</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Lambros Inc.</u>		ADDRESS <u>440-E North Ave</u>	

MINISTRE DES TRAVAUX PUBLICS
DEPARTMENT OF PUBLIC WORKS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
2444

Item 12, Film 6179 4-6-55 et

CERTIFICATE OF DEATH

02427
Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hosp</u>		STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lutherville, Md.</u> STREET ADDRESS (If rural give location) <u>307 Lincoln Avenue</u>	
3. NAME OF DECEASED: (Type or Print)		4. DATE (Month) (Day) (Year)	
First (Middle) (Last) <u>Martha</u> <u>---</u> <u>RASCH</u>		OF DEATH: <u>March 30</u> <u>19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>female</u>	<u>white</u>	<u>widow</u>	<u>11-15-1876</u>
9. AGE last birthday		10. IF UNDER 1 YEAR Months Days Hours Min.	
<u>78</u> yrs		<u>78</u> yrs	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>housewife</u>			
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Germany</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>Beinsen</u>		<u>unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>no</u>			
17. INFORMANT & ADDRESS:			
<u>Mrs. Dorothea R. Stewart</u> <u>307 Lincoln Ave. Lutherville, Md.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 IMMEDIATE CAUSE (A) <u>Respiratory and cardiac failure</u>			
ANTECEDENT CAUSE (S) DUE TO (B) <u>Intracerebral hemorrhages</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C) <u>Arteriosclerotic cardiovascular disease</u>			
<u>Para noid psychosis, senility</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>2 years</u>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>none</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>2/21</u> , 19 <u>55</u> , to <u>3/30</u> , 19 <u>55</u> that I last saw the deceased alive on <u>3/30</u> , 19 <u>55</u> , and that death occurred at <u>1:30 AM</u> from the causes and on the date stated above.			
SIGNATURE <u>Lindsey B. Campbell</u>		M.D. <u>Spring Grove State Hosp</u> <u>3-30-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Decatur Alabama</u>	
DATE THEREOF <u>4-2-1955</u>		LOCATION (City, town, or county) (State) <u>Decatur Alabama</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/30/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>	
		24. FUNERAL DIRECTOR ADDRESS <u>F.C. Hignibotham, Ellicott City, Md</u>	

MARGIN RESERVED FOR BINDING

VS. A15 -- 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 1 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

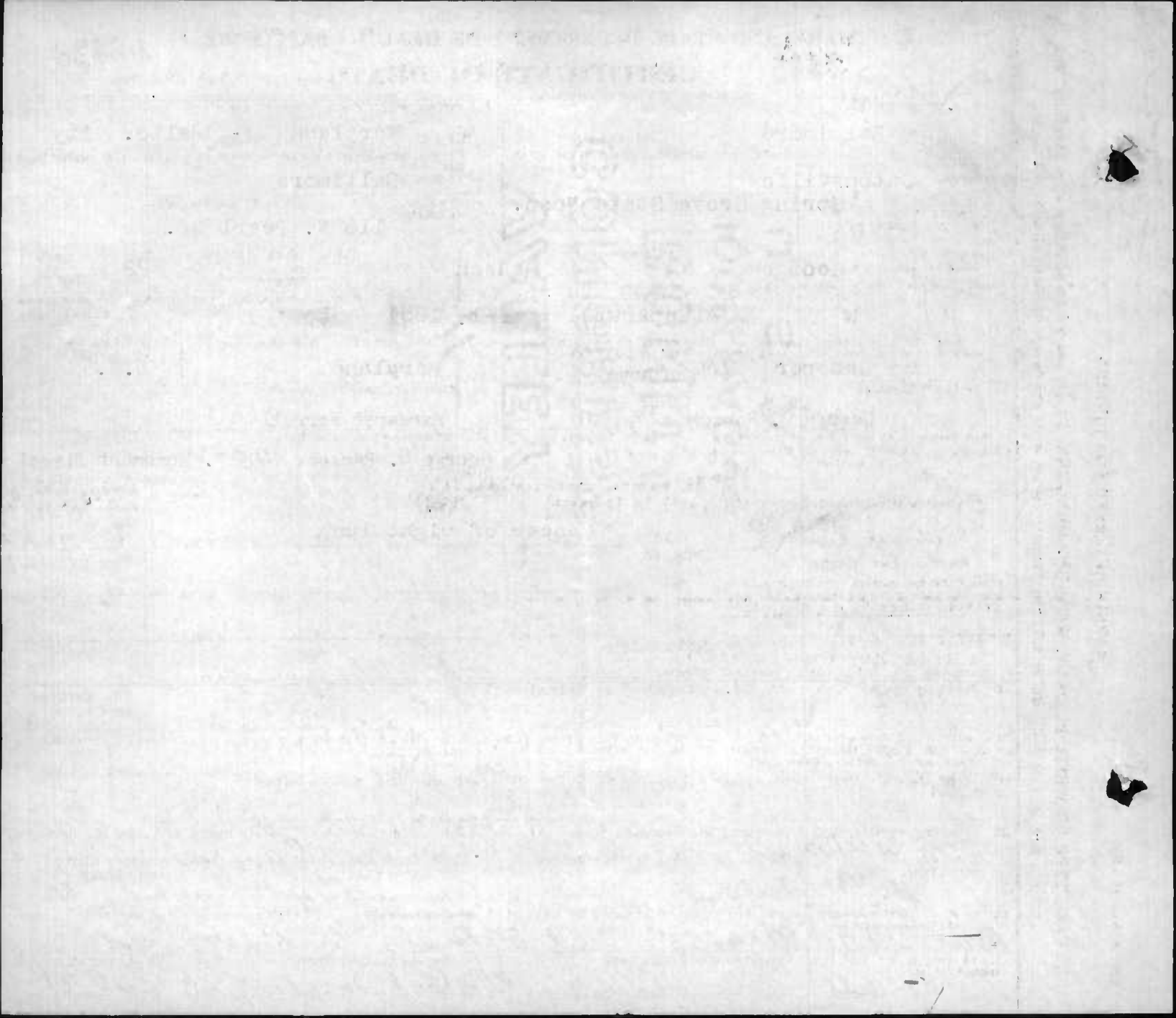
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2445

CERTIFICATE OF DEATH

Reg. Dist. No. 02428

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY Baltimore	MARYLAND	STATE Maryland	COUNTY Balto. City
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Catonsville	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baltimore	3601-4
HOSPITAL OR INSTITUTION OR STREET ADDRESS 14 Spring Grove State Hosp.		STREET ADDRESS (If rural give location) 116 N. Pearl St.	✓
3. NAME OF DECEASED: (First) George (Middle) G (Last) Rausch		4. DATE (Month) 3 (Day) 22 (Year) 1955	
5. SEX: M	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, SEPARATED	8. DATE OF BIRTH: May 9, 1897
9. AGE last birthday 57 yrs		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer		10B. KIND OF BUSINESS OR INDUSTRY: unknown	
11. BIRTHPLACE (State or foreign country): Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME: George G. Rausch		14. MOTHER'S MAIDEN NAME: Margaret Farrell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
If Yes, give war or dates of service		17. INFORMANT & ADDRESS: George G. Rausch, 2605 E. Monument Street	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
163X IMMEDIATE CAUSE (A) Cancer of right lung			2 1/2 year
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from 7/1/53 , to 3/22 , 19 55 , that I last saw the deceased alive on 3/22/55 , 19 55 , and that death occurred at 8.A M. from the causes and on the date stated above.			
SIGNATURE S. Wachler		DATE SIGNED 5/24/55	
23. BURIAL, CREMATION, REMOVAL (Specify)		24. FUNERAL DIRECTOR ADDRESS	
Burial		Wm Cook Inc. 1217 St. Paul St.	
DATE REC'D BY LOCAL REGISTRAR 5-23-55	REGISTRAR'S SIGNATURE D. W. Hedrick	LOCATION (City, town, or county) (State) Balto. Md.	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2447				02429			
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				Reg. Dist.			
Item 18 Film 3179 1-5-55 ans				No. 30			
1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN Catonsville		2 mon. 18 day		TOWN Havre de Grace		12-24-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Spring Grove State Hospital		STREET ADDRESS		(If rural, give location) Maryland	
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print)		Frank Reginaldi		3 18		19 55	
5. SEX:	6. COLOR OR RACE:	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.
M	W	Married	11-25-1888	66 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Fireman				Italy		USA	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Joseph Reginaldi				Teresa ?			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
no				Hospital records			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
903.7 Immediate cause (a) pending Sub dural hemorrhage							
Antecedent cause(s) (b) Cerebral compression							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) Uremia Chronic Nephritis							
Accident head injury							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office, bldg., etc.) OF INJURY		21c. (City or town) (County) (State)			
		Hospital		Catonsville Baltimore Maryland			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
3- 14 55 8:45 M.		1		fell coming out of shower causing small laceration on top of head			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		1010 Leek an		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED		3-18-55	
DEPUTY MEDICAL EXAMINER		M. D.		ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		3/22/55		Mt. Erie		Havre de Grace Md	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
3-21-55		A W Hedrick		Barrington Hor		Havre de Grace Md	

REPORT OF THE COMMISSIONER OF THE GENERAL LAND OFFICE
FOR THE YEAR 1894

ALBANY, N. Y., 1895

PRINTED BY THE COMMISSIONER OF THE GENERAL LAND OFFICE

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PRINTED BY THE COMMISSIONER OF THE GENERAL LAND OFFICE

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2448

02430

Reg. Dist.

No. 35

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Ind.</u>		COUNTY <u>Balto.</u>	
X CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>White Hall, Ind.</u>		LENGTH OF STAY (In this place) <u>2 yrs.</u>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>White Hall, Ind.</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bray Stone Rd.</u>				STREET ADDRESS (If rural, give location) <u>Bray Stone Rd.</u> 1			
3. NAME OF DECEASED: (Type or Print) <u>JOSEPH ESTIL REPASS</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Mar 26 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>		8. DATE OF BIRTH: <u>Aug 6, 1911</u>	
9. AGE last birthday: <u>43</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>		11. BIRTHPLACE (State or foreign country): <u>Tagewell, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Barley Repass.</u>				14. MOTHER'S MAIDEN NAME: <u>Maggie Harding</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No.</u>		16. SOCIAL SECURITY No.: <u>223-12-6544</u>		17. INFORMANT & ADDRESS: <u>Ely. Watkins (sister) White Hall, Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p>420.1 Immediate cause (a) <u>Coronary artery Disease</u> DUE TO</p> <p>Antecedent cause(s) (b) _____ DUE TO</p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) _____</p>							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None.</u>							
19a. DATE OF OPERATION: <u>None.</u>		19b. MAJOR FINDING OF OPERATION: <u>None.</u>					20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>None.</u>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>None.</u>		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None.</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>None.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>D. D. Caples</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED _____ DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/> <u>Mar 26 '55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>March 29, 1955</u>		NAME OF CEMETERY OR CREMATORY: <u>Wiseburg Cemetery</u>		LOCATION (City, town, or county) (State): <u>White Hall, Balto. Co., Md.</u>	
DATE REC'D BY LOCAL REG: <u>3/29/56</u>		REGISTRAR'S SIGNATURE: <u>[Signature]</u>		24. FUNERAL DIRECTOR: <u>Jacob Hartenstein</u>		ADDRESS: <u>New Freedom, Pa.</u>	

RECEIVED
APR 5 1955
BUREAU V. S.

02431

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2449

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>MD</i>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Cockeysville Md.</i>	LENGTH OF STAY (in this place) <i>9 yrs</i>	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Baltimore</i>	<i>3401-4</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Md. Masonic Home</i>		STREET ADDRESS (If rural give location) <i>1304 W. Lexington St</i>	
3. NAME OF DECEASED: (First) <i>Mary</i> (Middle) <i>H.</i> (Last) <i>Ridgaway</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>Mar. 7 1955</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <i>Aug. 9 - 1864</i>
9. AGE last birthday: <i>90</i> yrs.		10. IF UNDER 1 YEAR: Months <i>7</i> Days	11. IF UNDER 24 HRS. Hours Mln.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Taken care of home, own home</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>Talbot Co. Md</i>	
11. BIRTHPLACE (State or foreign country): <i>Talbot Co. Md</i>		12. CITIZEN OF WHAT COUNTRY:	
13. FATHER'S NAME: <i>William Wilson Todd</i>		14. MOTHER'S MAIDEN NAME: <i>Honora Gregory</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>None</i>		16. SOCIAL SECURITY No. <i>None</i>	
17. INFORMANT'S ADDRESS: <i>Laura M. Schroeder, Cockeysville</i>			

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422.1 IMMEDIATE CAUSE (A) <i>Arterio sclerosis</i>	DUE TO	
ANTECEDENT CAUSE (S) (B) <i>Cardiac Vascular Disease</i>	DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
-------------------------	----------------------------------	---

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from *10/23, 1946* to *Mar 7, 1955* that I last saw the deceased alive on *Mar 7, 1955* and that death occurred at *4:25 PM*, from the causes and on the date stated above.

SIGNATURE *Frank T. Kees* ADDRESS *Cockeysville Md* DATE SIGNED *3/7/55*

M. D.

23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>3/10/55</i>	DATE THEREOF	NAME OF CEMETERY OR CREMATORY <i>Mt. Olivet Cemetery</i>	LOCATION (City, town, or county) <i>Baltimore</i>
DATE REC'D BY LOCAL REGISTRAR <i>3/7/55</i>	REGISTRAR'S SIGNATURE <i>L. M. Schroeder</i>	24. FUNERAL DIRECTOR <i>Wm. Cook</i>	ADDRESS <i>St. Paul & Creston</i>

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 11 1955

RECEIVED

2450

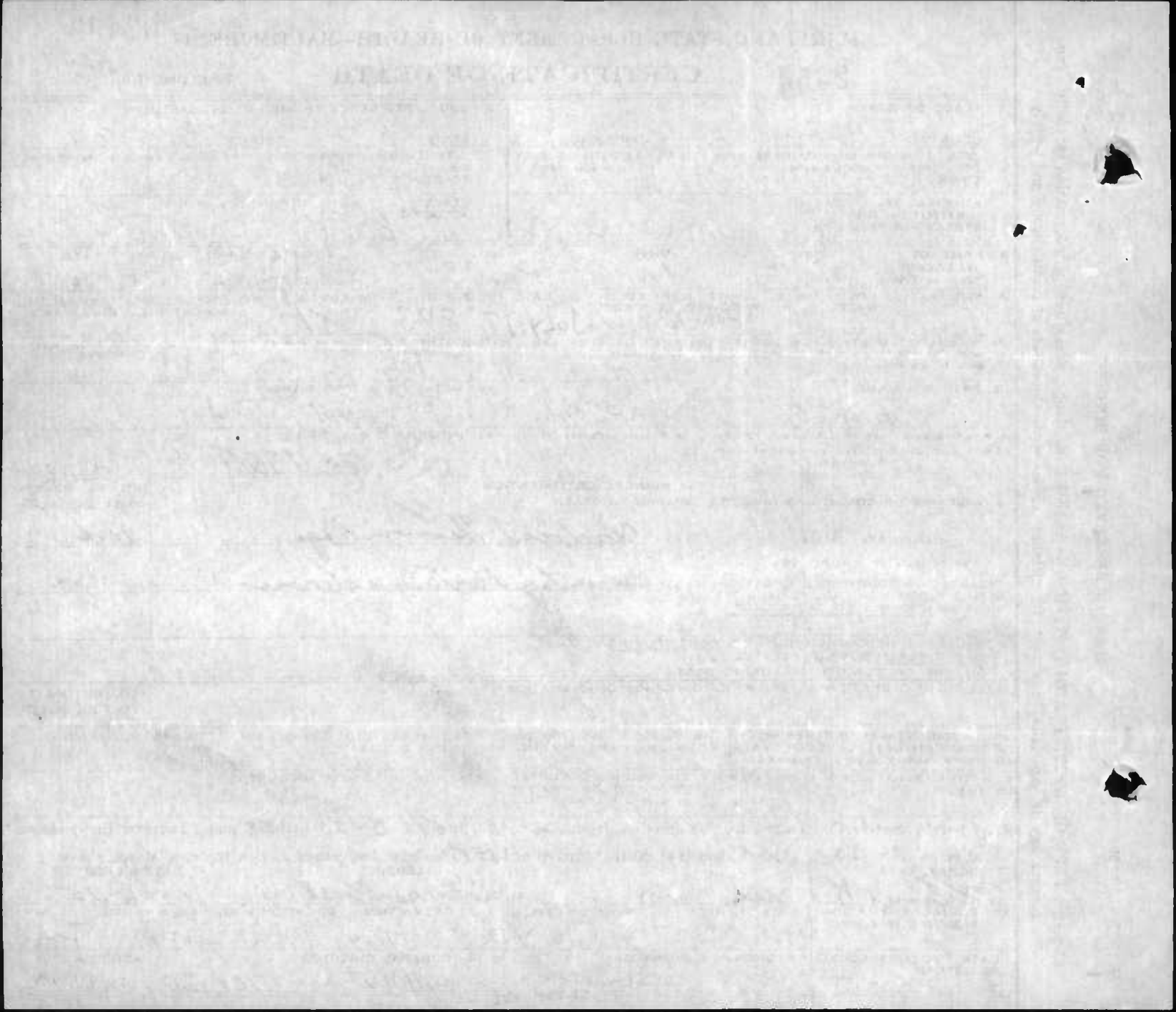
CERTIFICATE OF DEATH

Reg. Dist. No. 306

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD.</u> COUNTY <u>BALTO.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 TOWN CATONSVILLE</u>		LENGTH OF STAY (in this place) <u>4 MO.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>CATONSVILLE</u> <u>52</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 6 CEDARWOOD RD.</u>				STREET ADDRESS (If rural give location) <u>6 CEDARWOOD RD.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>MABEL M. RIGGS</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>MAR. 20 1955</u>			
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOW</u>	8. DATE OF BIRTH: <u>JULY 17, 1873</u>	9. AGE last birthday: <u>81</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>H.W.</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>O.H.</u>		11. BIRTHPLACE (State or foreign country): <u>PA.</u>		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME: <u>CHARLES R. SIMPSON</u>				14. MOTHER'S MAIDEN NAME: <u>ELEANOR PHILE</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>MR. CHARLES H. RIGGS, 6 CEDARWOOD</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>331X</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Cerebral Hemorrhage</u>						11 da.	
(B) <u>Generalized arteriosclerosis</u>						10 yrs.	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-18, 1954</u> to <u>3-20, 1955</u> , that I last saw the deceased alive on <u>3-20, 1955</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William K. Gallagher</u>		ADDRESS <u>M.D. Catonsville 28 Md.</u>		DATE SIGNED <u>3-22-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>MAR. 23/55</u>		NAME OF CEMETERY OR CREMATORY <u>FERNWOOD CEMETERY</u>		LOCATION (City, town, or county) (State) <u>PHILADELPHIA PA.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-23-55</u>		REGISTRAR'S SIGNATURE <u>R.W. Adair</u>		24. FUNERAL DIRECTOR <u>Harry H. Witzke</u>		ADDRESS <u>4101 EDMONDSON AVE.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2451

MARYLAND STATE DEPARTMENT OF HEALTH

02433

CERTIFICATE OF DEATH
FOR MEDICAL EXAMINERS

Reg. Dist. No. 30

1. PLACE OF DEATH - COUNTY <u>BALTO CO</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>MD</u> COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 CATONSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00 39 WADE AVE</u>		STREET ADDRESS (If rural, give location) <u>39 WADE AVE.</u>	
3. NAME OF DECEASED (First) <u>JAMES</u> (Middle) <u>ITERWIN</u> (Last) <u>RIORDAN</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>15</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>1/8/1904</u>
9. AGE last birthday <u>51</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>MD</u>	
11. BIRTHPLACE (State or foreign country) <u>MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DENNIS J. RIORDAN</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE CULLEN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>JOSEPH RIORDAN</u>	

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause

(a)

Coronary thrombosis

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

3-18-55

T.E. Harvey

MACNABB & SON

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
MAR 21 1955
BUREAU V. S.

02434

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 30

Item 9, File G179 3-21-55 et

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE MD 3401-4</u>	
TOWN <u>90</u>		TOWN <u>90</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>RIDGEWAY MANOR NURSING HOME</u>		STREET ADDRESS (If rural give location) <u>1041 Pine Sts Ave</u>	
3. NAME OF DECEASED (First) <u>ROSIE</u> (Middle) <u>RUEHL</u> (Last)		4. DATE OF DEATH (Month) <u>MARCH</u> (Day) <u>9</u> (Year) <u>1955</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>Sept 30, 1867</u>
9. AGE last birthday <u>87</u> yrs.		10. AGE last birthday (If under 1 year) Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>NONE</u>	
17. INFORMANT <u>MILTON RUEHL 3501 Coolidge Ave</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause (a) CORONARY Occlusion

Antecedent cause(s) (b) GEN. A.S.

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) A.S.C.U.D.

INTERVAL BETWEEN ONSET AND DEATH

10 hours

20 yrs (?)

20 yrs (?)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐
(STATE)

21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)
SUICIDE	INJURY		
HOMICIDE			
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED While at Not While	HOW DID INJURY OCCUR?	
OF INJURY	m. Work <input type="checkbox"/> At work <input type="checkbox"/>		

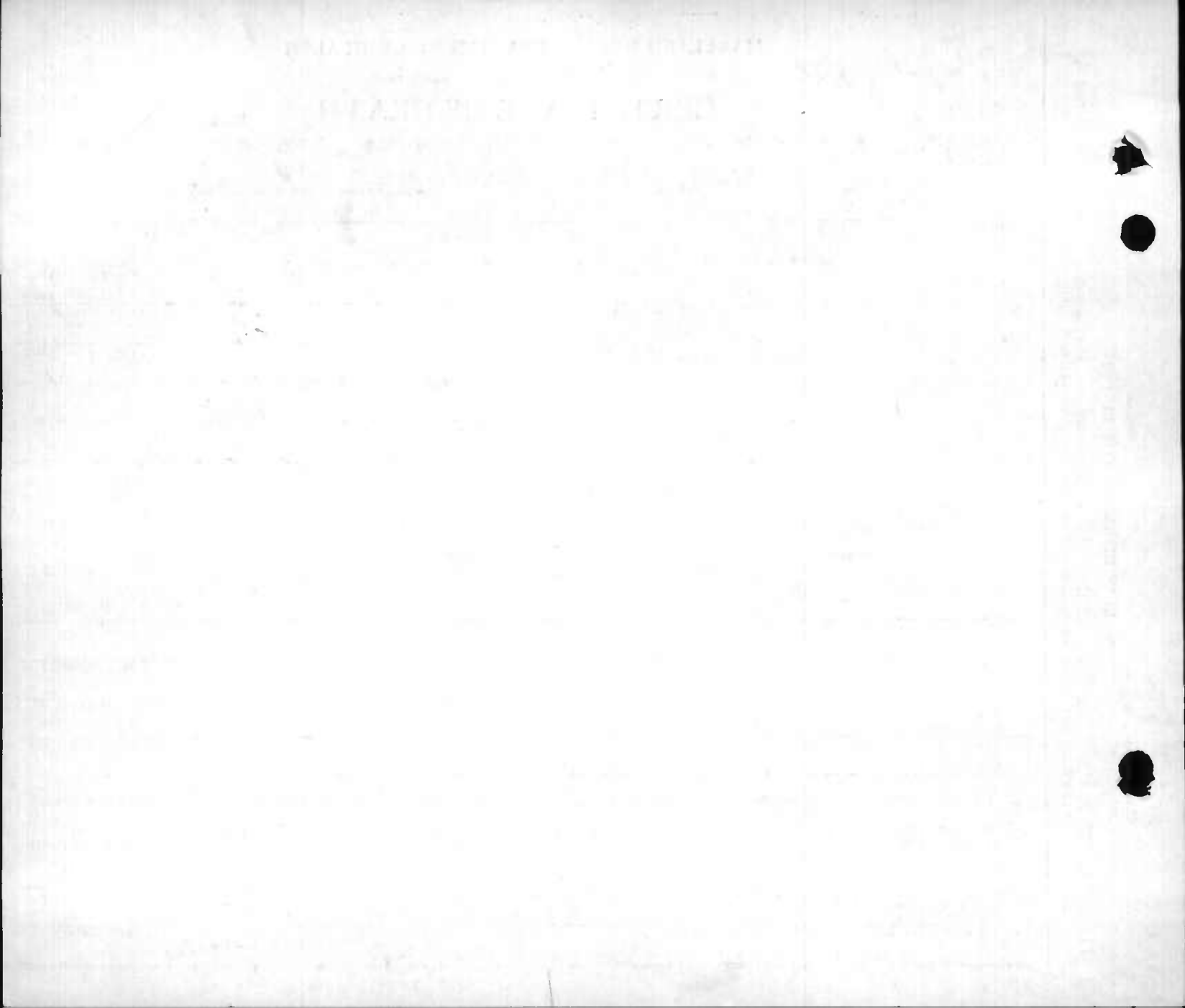
22. I hereby certify that I attended the deceased from 2/25, 1955, to 3/9, 1955, that I last saw the deceasedalive on 3/8, 1955, and that death occurred at 5 A. m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

23. BURIAL, CREMATION REMOVAL <u>1922</u>	DATE THEREOF <u>3-11-55</u>	NAME OF CEMETERY OR CREMATORY <u>RODON PARK CEM</u>	LOCATION (City, town, or county) <u>BALTIMORE MD</u>
DATE REC'D BY LOCAL REG. <u>3-10-55</u>	REGISTRAR'S SIGNATURE <u>R W Federal</u>	24. FUNERAL DIRECTOR <u>PRATT & STRICKER & S</u>	ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2453

CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (if outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <u>Catonsville</u>	<u>8 mrs. 3 wks</u>	TOWN <u>Baltimore 7</u> <u>3 Vol-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (if rural give location)		
<u>Spring Grove State Hosp</u>	<u>4502 Kathland Ave. v</u>		
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year)	
(First) <u>Nellie</u>	(Middle) <u>Segrue</u>	(Last) <u>Ryan</u>	DATE OF DEATH: <u>3-7</u> <u>1955</u>
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify): <u>W</u>	8. DATE OF BIRTH: <u>Nov. 14</u>
9. AGE last birthday <u>81</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Milliner</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>James Segrue</u>		14. MOTHER'S MAIDEN NAME: <u>Bridget</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Hospital records</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Cerebrovascular thrombosis</u>		<u>1 day</u>
ANTECEDENT CAUSE (B) <u>Cerebral arteriosclerosis</u>		<u>unk.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized arteriosclerosis</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
-------------------------	----------------------------------	--

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
--	--	--

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
---	--	----------------------------

22. I hereby certify that I attended the deceased from 6-18, 1954, to 3-7, 1955, that I last saw the deceased alive on 3-7, 1955, and that death occurred at 11:45 P M, from the causes and on the date stated above.

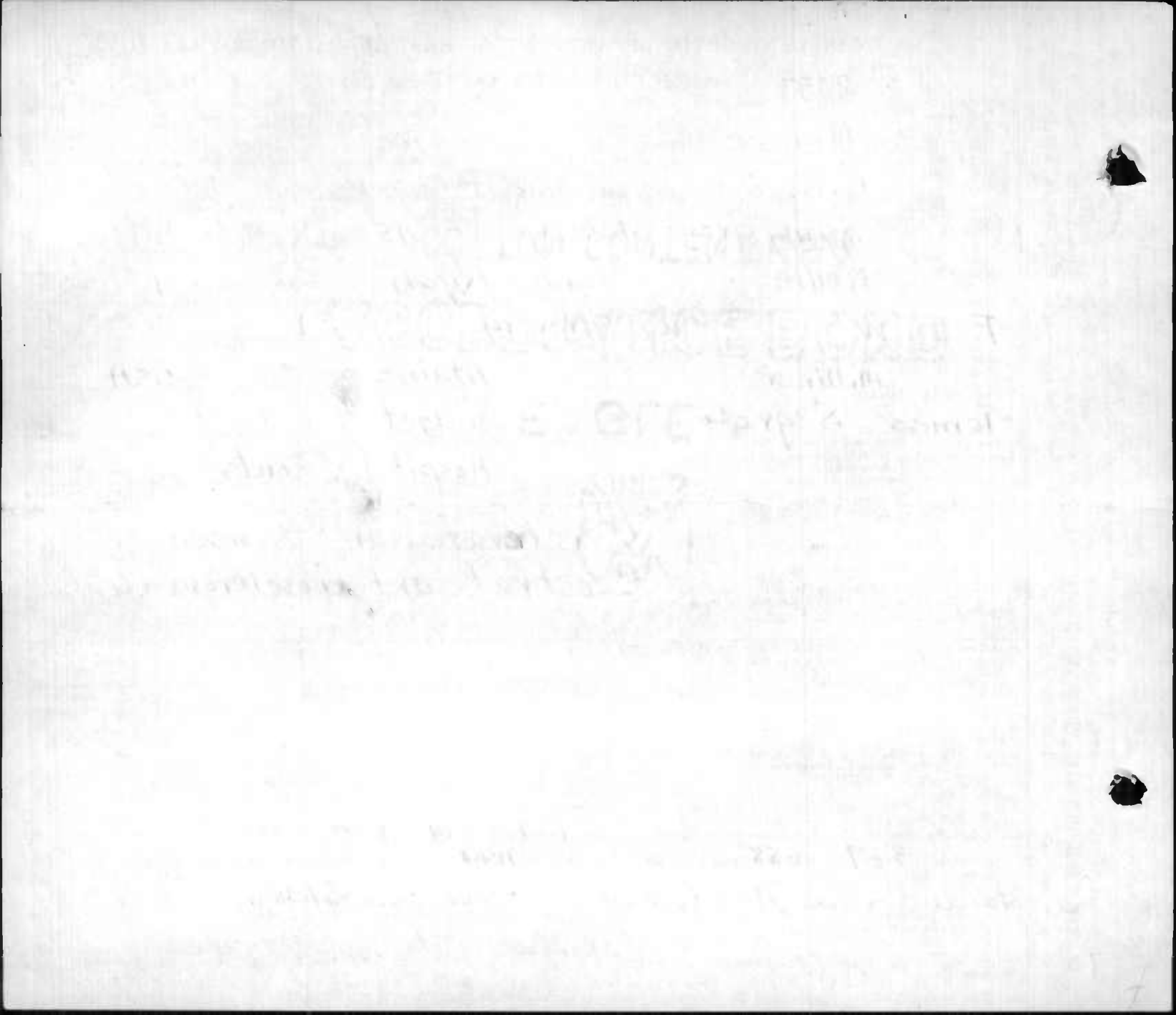
SIGNATURE Louise Frances Woodward ADDRESS M. D. Spring Grove State Hosp. DATE SIGNED 3-7-55

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>Mar 10/1955</u>	<u>Not listed</u>	<u>Washington DC</u>

DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3-8-55</u>	<u>G. W. Hedden</u>	<u>Harry M. Minaros</u>	<u>4204 Ridgewood Ave</u>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

02436

2451

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Raspeburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>#397, King Avenue</u>		STREET ADDRESS (If rural, give location) <u>#397, King Ave.</u>	
3. NAME OF DECEASED (First) <u>CATHERINE SAHLMAN</u> (Middle) (Last)		4. DATE OF DEATH Month <u>March</u> Day <u>10th</u> Year <u>1955</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 17, 1888</u>
9. AGE last birthday <u>66</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>John Christ</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Stevens</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>none</u>	
17. INFORMANT AND ADDRESS <u>Mr. J. M. Sahlman, 397 King Ave. Balto. 6, Md.</u>			

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

INTERVAL BETWEEN ONSET AND DEATH

Sudden1 yr

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 1, 1955, to March 10, 1955, that I last saw the deceasedalive on March 10, 1955, and that death occurred at 4 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

7401 Belair Rd.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Dr. Baumgardner

MARYLAND STATE DEPARTMENT OF HEALTH

02437

2411 N. Charles Street, Baltimore

2322

CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
51 CITY (If outside corporate limits, write RURAL and give nearest town) <u>Landsdowne</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Landsdowne</u> 51	
TOWN <u>Landsdowne</u>		TOWN <u>Landsdowne</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>137 Clyde Avenue</u>		STREET ADDRESS (If rural give location) <u>137 Clyde Avenue</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>Naula</u> (Middle) <u>Saral</u> (Last) <u>Saral</u>		4. DATE OF DEATH (Month) <u>3</u> (Day) <u>8</u> (Year) <u>1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>1871</u>
9. AGE last birthday <u>84</u> yrs.		If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>	
11. BIRTHPLACE (State or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Israel Israelson</u>		14. MOTHER'S MAIDEN NAME <u>Freda</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>2815 Hilldale Ave</u>	
17. INFORMANT <u>Mrs. Nellie Jeffers</u>		<u>Baltimore</u>	

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
151X Immediate cause (a) <u>Carcinoma of Stomach</u>	
Antecedent cause(s) (b) <u>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last</u>	
(c)	
II. OTHER SIGNIFICANT CONDITIONS	
Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION <u>about Oct. 1954</u>	19b. MAJOR FINDINGS OF OPERATION <u>Carcinoma of Stomach</u>
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

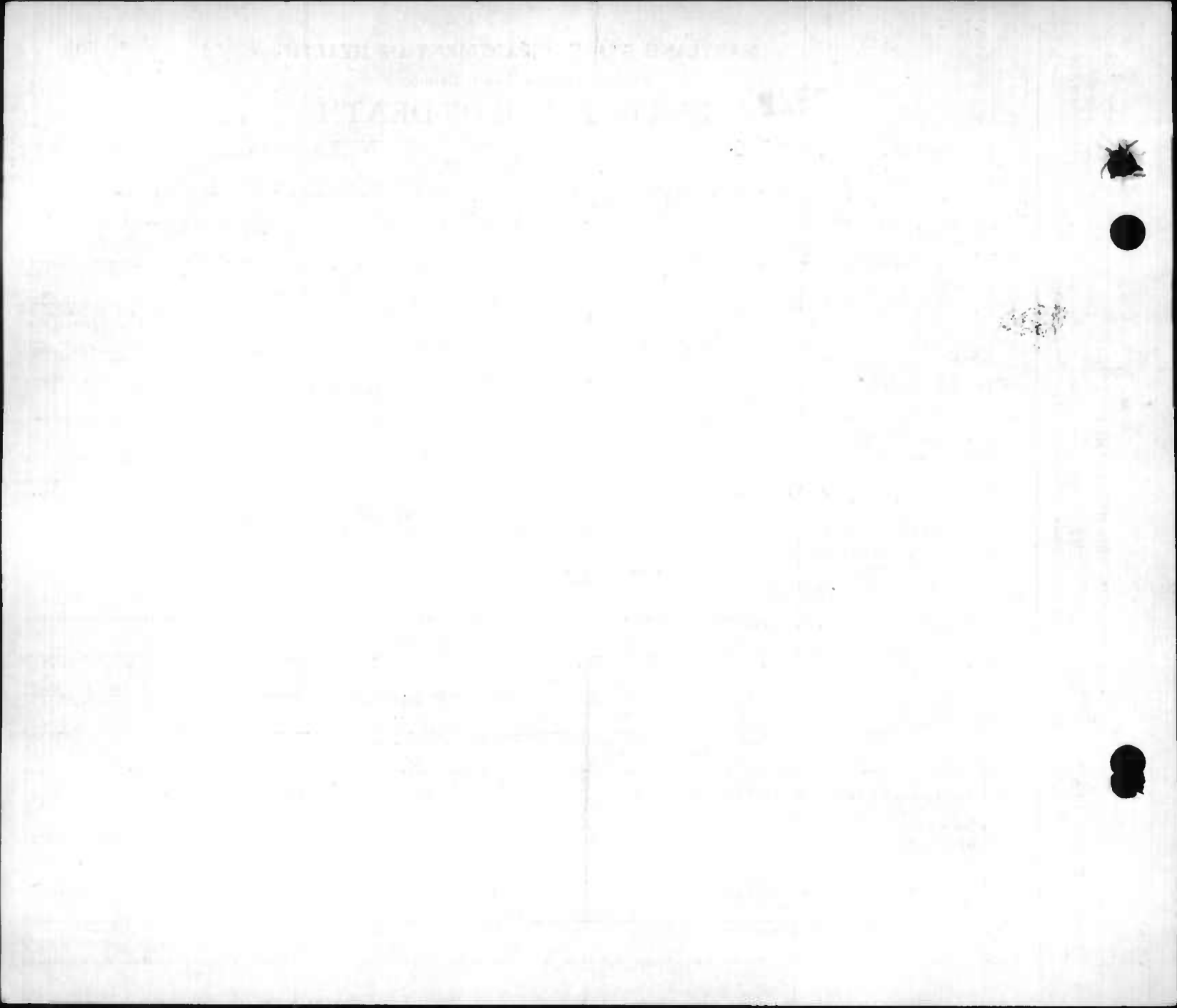
22. I hereby certify that I attended the deceased from about 1940, to 3-8, 1955, that I last saw the deceased alive on 3-8, 1955, and that death occurred at 4:15 p.m., from the causes and on the date stated above.

SIGNATURE R. Highstein M.D. ADDRESS 888 W. Lombard St DATE SIGNED 3-9-55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Mar 8/55</u>	NAME OF CEMETERY OR CREMATORY <u>Anshe Gynah</u>	LOCATION (City, town, or county) <u>Baltimore, Md.</u>	(State)
DATE REC'D BY LOCAL REG. <u>3-9-55</u>	REGISTRAR'S SIGNATURE <u>AW [Signature]</u>	24. FUNERAL DIRECTOR <u>ONE</u>	ADDRESS <u>1124-26 W. North Avenue</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH

02438

2323

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Balt</u>	
57 CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Arbutus</u> 57	
TOWN <u>Arbutus</u>		TOWN <u>Arbutus</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4301 Alan Drive</u>		STREET ADDRESS (If rural, give location) <u>4301 Alan Drive</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>George W. Schaefer</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 13 1955</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>married</u>	8. DATE OF BIRTH <u>11/2/1881</u>
9. AGE last birthday <u>73</u> yrs.		10. If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Continental Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>Martin Schaefer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Wicklein</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>-</u>		16. SOCIAL SECURITY No. <u>-</u>	
17. INFORMANT AND ADDRESS <u>Mrs Anna M. Schaefer</u>		<u>4301 Alan Drive</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

4222

Immediate cause

(a) Chronic Myocarditis and myocardial degeneration

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

INTERVAL BETWEEN ONSET AND DEATH

2 years

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from June 8, 1953, to March 13, 1955, that I last saw the deceased alive on March 8, 1955, and that death occurred at 11:45 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

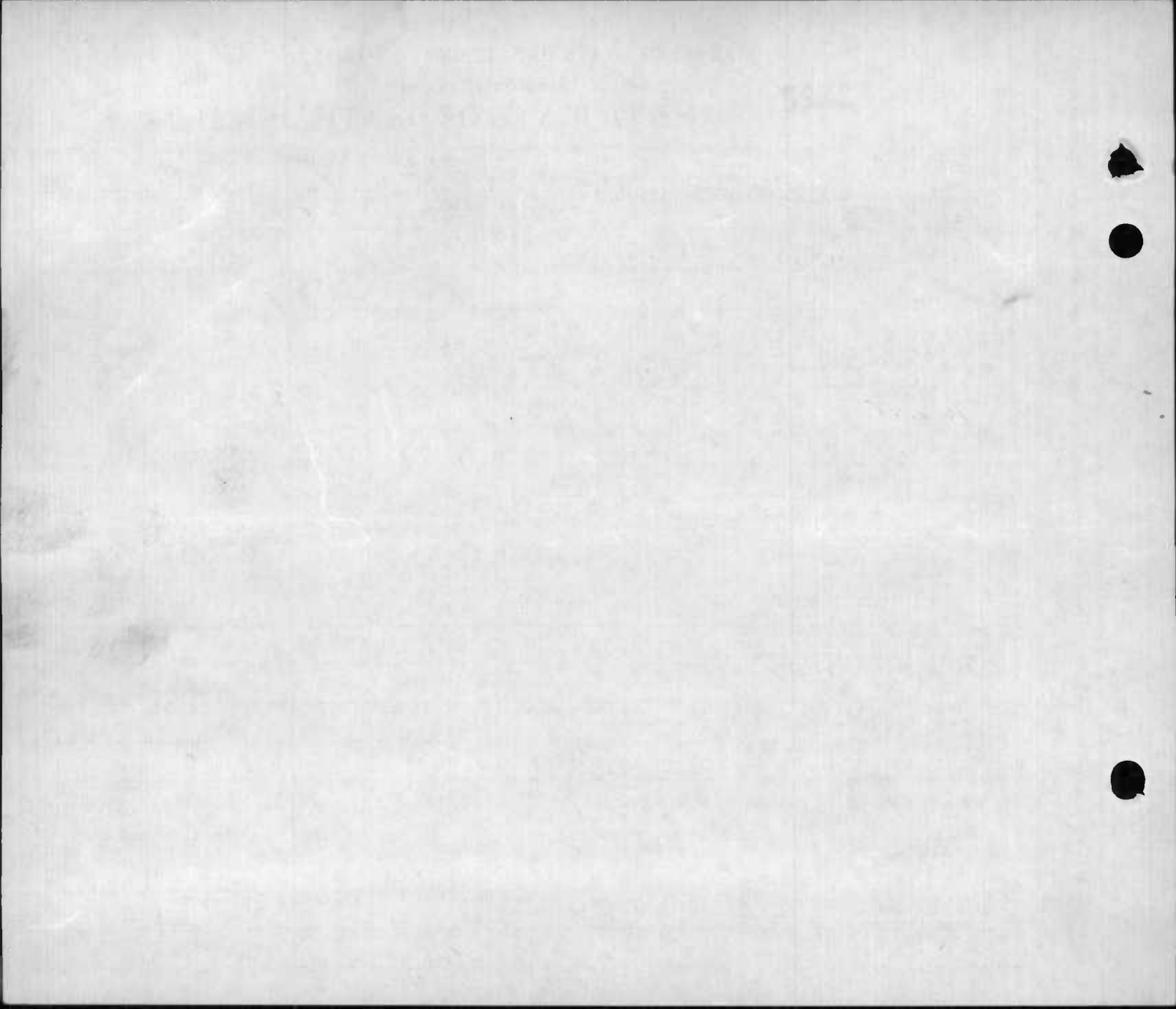
DATE SIGNED

Melvin N. BordenM.D. 5000 Old Frederick Road Balt 293/14/55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>3/16/55</u>	NAME OF CEMETERY OR CREMATORY <u>Oak Lawn Cem.</u>	LOCATION (City, town, or county) (State) <u>7225 Eastern Ave. St.</u>
DATE REC'D BY LOCAL REG. <u>3/14/55</u>	REGISTRAR'S SIGNATURE <u>A. W. H. Smith</u>	24. FUNERAL DIRECTOR <u>John J. Cowan Son</u>	ADDRESS <u>Hollins</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2455

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u> MARYLAND			STATE <u>Maryland</u> COUNTY <u>Baltimore</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Parkville</u>			CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>Parkville</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1604 Orlando Road</u>			STREET ADDRESS (If rural give location) <u>1604 Orlando Avenue #14</u>		
3. NAME OF DECEASED: (First) (Middle) (Last)			4. DATE (Month) (Day) (Year)		
Mrs. <u>Ella R.</u> <u>Scherschel</u>			OF DEATH: <u>March 22nd</u> <u>1955</u>		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR
<u>female</u>	<u>white</u>	<u>widowed</u>	<u>May 24, 1886</u>	<u>68</u> yrs.	Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>at home</u>			10B. KIND OF BUSINESS OR INDUSTRY:		
			<u>Baltimore, Maryland</u>		
11. BIRTHPLACE (State or foreign country):			12. CITIZEN OF WHAT COUNTRY?		
<u>USA</u>			<u>USA</u>		
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
<u>Lezers</u>			<u>?</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			15. SOCIAL SECURITY No.		
			17. INFORMANT & ADDRESS:		
			<u>Mr. John H. Neal Hyde Maryland</u>		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>Sudden (seconds)</u>
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A)	<u>Coronary Thrombosis</u>	
ANTECEDENT CAUSE (B)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<u>None</u>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from Sept., 1954, to 22 March, 1955, that I last saw the deceased alive on Jan 15, 1955, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

SIGNATURE <u>Edward L. Muf</u>		ADDRESS <u>7425 Harford Rd</u>		DATE SIGNED <u>22 March 55</u>	
M. D.					
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Mar. 25, 1955</u>		<u>Holy Redeemer Cemetery</u>	
				<u>Baltimore, Maryland</u>	
24. FUNERAL DIRECTOR		ADDRESS			
<u>Leonard J. Ruck</u>		<u>5305 Harford Road #14</u>			
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE			
<u>8-23-55</u>		<u>A. W. Beddy</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Molz
7425 Harford Road

Please Call HA 6 1460 when ready.

M.R.G.

MARYLAND STATE DEPARTMENT OF HEALTH

02440

2411 N. Charles Street, Baltimore

2456

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH- COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Fullerton md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fullerton md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Joppa Rd</u>		STREET ADDRESS (If rural, give location) <u>Joppa Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Caroline S Schwartz</u>		4. DATE OF DEATH <u>March 27</u> 19 <u>55</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Jan 11-1876</u> 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN. Home</u>	11. BIRTHPLACE (State or foreign country) <u>Balto Co md</u>
13. FATHER'S NAME <u>John Dietz</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>Katherine Pilhofer</u>	
16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT AND ADDRESS <u>Mrs W. Schwartz Joppa Rd</u>	

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1
Immediate cause

(a)

Cerebral anoxia

INTERVAL BETWEEN ONSET AND DEATH

6 hrs.

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Congestive heart failure4 hrs.

(c)

Myocardial infarction6 hrs.

II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURYINJURY OCCURRED
While at Work ☐ Not While At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Feb 1, 1955, to March 27, 1955, that I last saw the deceasedalive on March 26, 1955, and that death occurred at 1:15 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

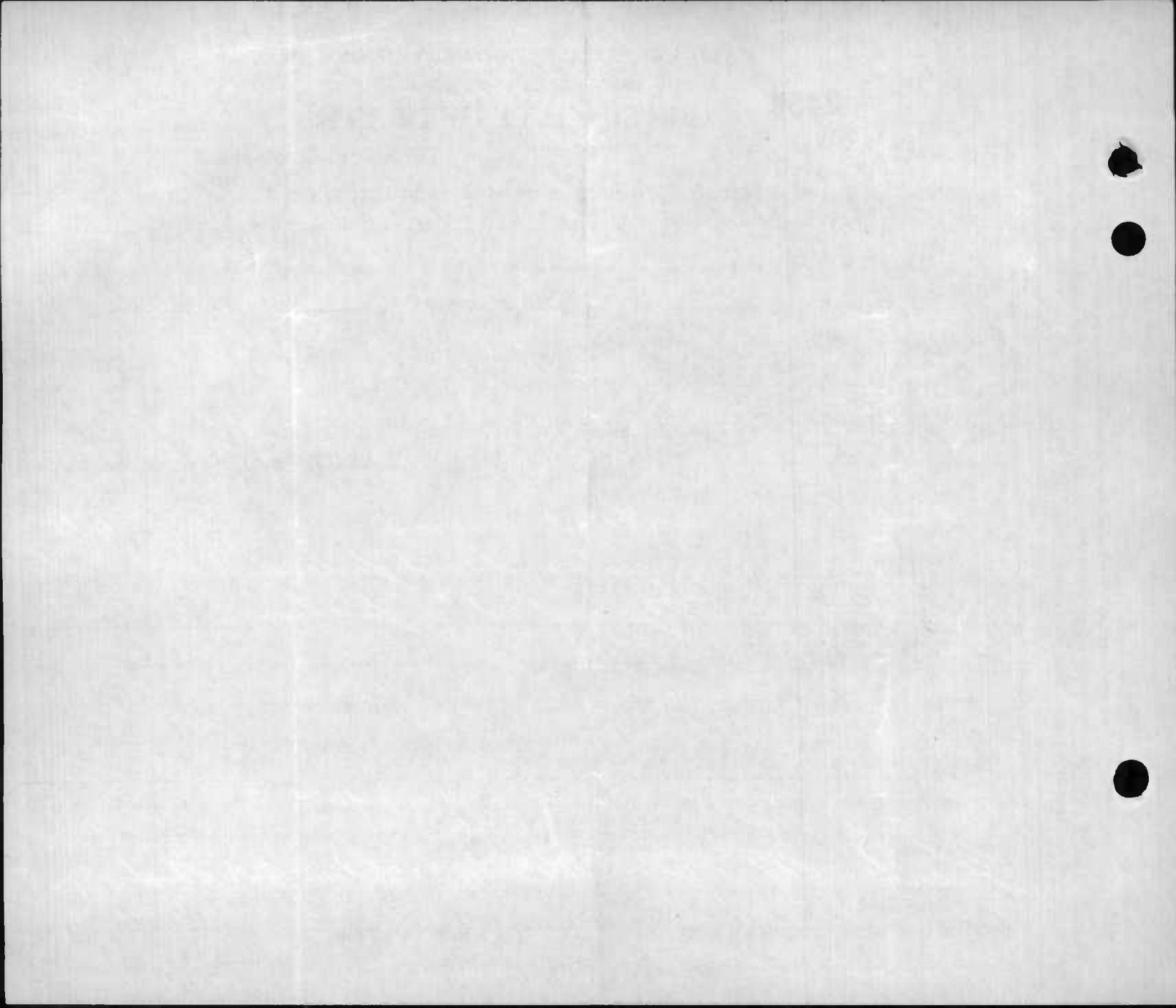
DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Druce



2457

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Owings Mills				TOWN Aberdeen		12-31-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rosewood State Tr. School				STREET ADDRESS (If rural give location) 207 Ryland Drive			
3. NAME OF DECEASED: (First) Albert		(Middle) Ray		(Last) Scott, Jr.		4. DATE OF DEATH: (Month) 3 (Day) 8 (Year) 19 55	
5. SEX: male	6. COLOR OR RACE: W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: 12/11/46		9. AGE last birthday: 8 yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): ---		10b. KIND OF BUSINESS OR INDUSTRY: ---		11. BIRTHPLACE (State or foreign country): Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME: Albert Ray Scott, Sr.				14. MOTHER'S MAIDEN NAME: Geraldine Simen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): ---		16. SOCIAL SECURITY NO.: ---		17. INFORMANT & ADDRESS: Rosewood Records, Owings Mills, Md.			

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
570.0 Immediate cause (a) Paralytic Ileus and Peritonitis		a few days
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Intussusception of Ileum		a few days
(c)		

11. OTHER SIGNIFICANT CONDITIONS		Congenital malformation of brain		since birth
Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?		Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
HOMICIDE	INJURY			
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 9/17, 19 52, to 3/8/19 55, that I last saw the deceased alive on 3/8/19 55, and that death occurred at 11:20 a.m., from the causes and on the date stated above.

SIGNATURE Sister B. Johns		(Degree or title) M.D.		ADDRESS Rosewood St. School Owings Mills, Md.		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)			
Burial	3-12-55	St LORETTA	All eghany Co Pa				
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR		ADDRESS			
3-9-55	Mary B. Elme	J. S. Elme and Sons		Reisterstown Md.			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 5

MAR 16 1955

RECEIVED

2458

CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>BALTO.</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<u>X</u> TOWN <u>WOODLAWN Md</u>	<u>4</u>	TOWN <u>BALTO.</u>	<u>3401-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS	(If rural give location)
<u>90</u> <u>AUGSBURG HOME</u>		<u>6811 CAMPFIELD Rd</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First) <u>ANNA</u>	(Middle) <u>MARG.</u>	(Last) <u>SEIFRIED</u>	(Month) <u>MARCH</u> (Day) <u>29</u> (Year) <u>1955</u>
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOW</u>	8. DATE OF BIRTH: <u>OCT. 10, 1883</u>
9. AGE last birthday: <u>71</u> yrs.		10. BIRTHPLACE (State or foreign country): <u>BALTO. Md</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>JOSEPH WESTERKAM.</u>		14. MOTHER'S MAIDEN NAME: <u>FREDERICA VOGEL</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:	
(If Yes, give war or dates of service)		17. INFORMANT & ADDRESS: <u>RECORDS AUGSBURG HOME</u>	

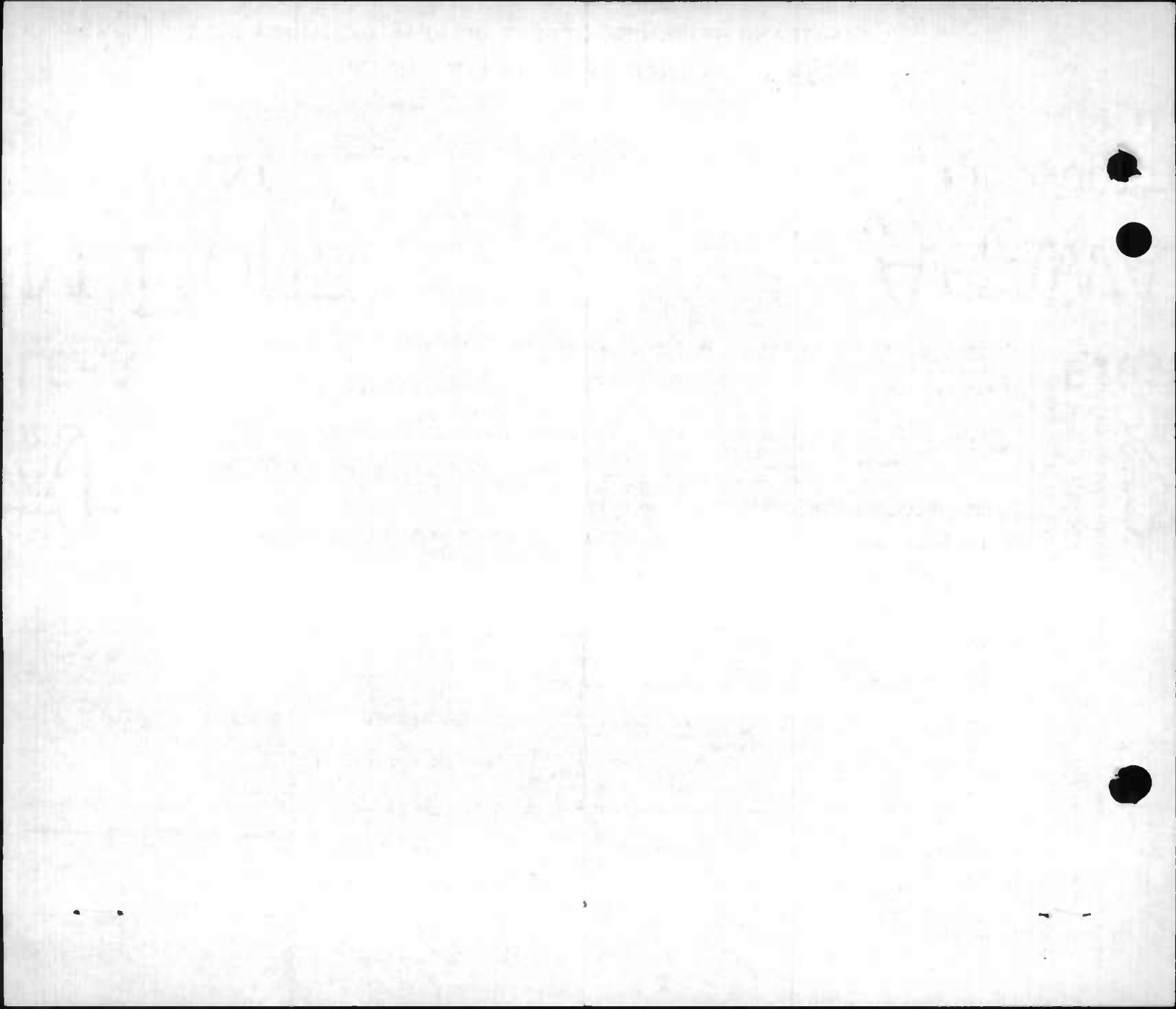
18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Virus Pneumonia</u>		<u>6 wks.</u>
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Cerebral Hemorrhage</u>		<u>5 days</u>
(c)		

11. OTHER SIGNIFICANT CONDITIONS		20. AUTOPSY ?	
Conditions contributing to the death but not related to the disease or condition causing death. <u>Incurable bolitis</u>		<u>2 yrs.</u>	
19a. DATE OF OPERATION: <u>none</u>		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED	
m.		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR ?			

22. I hereby certify that I attended the deceased from <u>Jan. 15</u> , 19 <u>50</u> , to <u>March 29</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>March 24</u> , 19 <u>55</u> , and that death occurred at <u>Baltimore 7-Md-3-29-55</u> , from the causes and on the date stated above.			
SIGNATURE		ADDRESS	
<u>Paul L. Chamberlain M.D.</u>		<u>4108 Liberty Hts C Baltimore 7-Md-3-29-55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF	NAME OF CEMETERY OR CREMATORY
<u>BURIAL</u>		<u>4/1/55</u>	<u>BALTO. Cem.</u>
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR
<u>3-30-55 E. W. Hedrick</u>		<u>Paul Hedrick</u>	ADDRESS
			<u>6067 Harford Rd</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2459

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH:

COUNTY **Baltimore** MARYLAND
 CITY (If outside corporate limits, write RURAL OR and give nearest town) **Randelstown** LENGTH OF STAY (in this place)
 HOSPITAL OR INSTITUTION OR STREET ADDRESS **8306 Liberty Rd.**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Md.** COUNTY **Baltimore**
 CITY (If outside corporate limits, write RURAL and give nearest town) **Randelstown**
 STREET ADDRESS (If rural, give location) **8306 Liberty Rd.,**

3. NAME OF DECEASED:

(First) (Middle) (Last)
Mary E. Shupp

4. DATE OF DEATH: (Month) (Day) (Year)
Mar. 8, 1955

5. SEX:

female

6. COLOR OR RACE:

white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) **Married**

8. DATE OF BIRTH:

1900

9. AGE last birthday:

54

IF UNDER 1 YEAR IF UNDER 24 HRS.
 Months Days Hours Min.
 yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **housewife**

10b. KIND OF BUSINESS OR INDUSTRY: **home**

11. BIRTHPLACE (State or foreign country): **Maryland**

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

Otho J. Shank

14. MOTHER'S MAIDEN NAME:

Cline

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.: **?**

17. INFORMANT & ADDRESS:

Mr. Bast Boonsboro, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

260X
 Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

INTERVAL BETWEEN ONSET AND DEATH

21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While nt Not while work at work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **3-6-55**, to **3-8-55**, that I last saw the deceased alive on **3-8-55**, and that death occurred at **6:35** am., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Bast Funeral Home Boonsboro, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 14 1955

RECEIVED

Handwritten signature

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 102444
2460 CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Ann Arundel</u>			
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place) <u>11mo. 11days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Riva</u> <u>02X-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>				STREET ADDRESS (If rural give location) <u>✓</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>James Smallwood</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>March 31, 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH: <u>July 19th, 1881</u>	9. AGE last birthday <u>73</u> yrs	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Carpenter</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Rubin Smallwood</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>450.0 Congestive heart failure</u>							
ANTECEDENT CAUSE (S) <u>Generalized arteriosclerosis</u>						Years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic brain syndrome assoc. w/ senile brain</u>						Years	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4-20-</u> , 19 <u>54</u> to <u>3-31-</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/31</u> , 19 <u>55</u> , and that death occurred at <u>3:25 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>S. Wachsler</u>		ADDRESS <u>Spring Grove State Hospital</u>		DATE SIGNED <u>3-31-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>April 2, 55</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		LOCATION (City or town) (County) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>4-2-55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harris</u>		24. FUNERAL DIRECTOR <u>F. B. Wippert,</u>		ADDRESS <u>1300 Eutaw Pl</u>	

BUREAU V. S.

APR 22 1953

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2461

CERTIFICATE OF DEATH

Reg. Dist. No. XX

02445

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>4 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>6218 Shipview Way</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>GEORGE Richards SMITH</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>March 25, 1955</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>August 20, 1891</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Painter</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>William S. Smith</u>				14. MOTHER'S MAIDEN NAME: <u>Nellie Gorsuch</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WW-I</u>				16. SOCIAL SECURITY NO. <u>219-03-6830</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>420.1</u>						UNKNOWN	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						UNKNOWN	
(A) MYOCARDIAL INFARCTION DUE TO ARTERIOSCLEROSIS OF CORONARY ARTERIES WITH THROMBOSIS							
(B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 21, 1955</u> , to <u>Mar. 25, 1955</u> , that I was with the deceased at <u>5:45 AM</u> , and that death occurred at <u>5:45 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William B. VanDeGrift, M.D.</u>				ADDRESS <u>M. D. VAH, Fort Howard, Maryland</u>		DATE SIGNED <u>3-25-55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Mar. 28, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Wards Chapel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-28-55</u>		REGISTRAR'S SIGNATURE <u>Dr. Hedrick</u>		24. FUNERAL DIRECTOR <u>Wm. Flickner & Sons Funeral Home</u> North & Pennsylvania Aves., Baltimore, Md.			

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2462

County
BALTIMORE CITY HEALTH DEPARTMENT
CERTIFICATE OF DEATH

Registered No.

02446

1. PLACE OF DEATH:

- (a) Baltimore City, Maryland
 (b) Street address *Smith Ave. Baltor*
 (c) Hospital or institution: *md.*
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *00*
 (e) Length of stay in Baltimore (yrs., mos., or *days*) *1*

2. USUAL RESIDENCE OF DECEASED:

- (a) State *md* (b) County *Balto.*
 (c) City or town *Smith Ave., Baltor 9, md*
 (If outside city or town limits, write RURAL and give town)
 (d) Street No. *Smith Ave.*
 (If rural give location)
 (e) Citizen of foreign country? *no* (Yes or No)
 If yes, name country

3 (a) FULL NAME *Mitchell Benjamin Smith*3 (b) If veteran, name war *no*3 (c) Social Security Account
No. *255-01-0621*4. Sex *M* 5. Color or race *W* 6 (a) Single, married, widowed, or divorced. *M*6 (b) Name of husband or wife *Margaret Christine*
6 (c) If alive, give age *37* years7. Birth date of deceased (mo., day, yr.) *JUN 14, 1889?*8. AGE: Years *65* Months *8* Days *4* If less than one day
hr. min.9. Birthplace *Sullivan County, Tenn.*
(Town, county, and state)

10. Usual Occupation

11. Industry or business

12. Name *HENRY SMITH*

13. Birthplace

14. Maiden Name?

15. Birthplace

16 (a) Informant *Wife*

(b) Address

17 (a) *BURIAL* (b) Date thereof *3 21 55*
(Burial, cremation, or removal) (month) (day) (year)(c) Cemetery or crematory *MT OLIVE*Location *RANDALLS TOWN MD*18 (a) Funeral director *FRANK H NEWELL*(b) Address *Pikesville MD*19 (a) *MARCH 18, 1955* (b) *Martha A. Newell*
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *18 March* 1955, at *11 A* M21. I certify that death occurred on the date above stated; that I attended deceased from *18 March* 1955, to *18 March* 1955, and that I last saw him alive on *18 March* 1955.

Immediate cause of death

Coronary thrombosis

Duration

1 day

Due to

420.1

Due to

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur?
(City or town) (County) (State)(d) Did injury occur about home, on farm, industrial place, in public place?
(Specify type of place) While at work?

(e) Means of injury

23. Signature *Charles H. Williams, M.D.*
M. D.Address *Pikesville 8, Md.* Date signed

INSTRUCTIONS FOR MEDICAL CERTIFICATION

WHAT IS A "CAUSE OF DEATH"?

For the death certificate, a cause-of-death statement should involve only those disease entities which have contributed to the death. Symptoms or findings are not wanted except as they are needed in determining the underlying cause of death.

DEFINITION OF IMMEDIATE CAUSE OF DEATH:

The last of a series of disease entities which contribute to a death will be known as the immediate cause of death. When there is only one disease entity present, this becomes the immediate cause of death.

DEFINITION OF UNDERLYING CAUSE OF DEATH:

The disease entity which initiates the series of disease entities resulting in death will be known as the underlying cause of death. When there is only one disease entity present, the underlying cause of death and the immediate cause of death are considered to be identical. The underlying cause of death should be written in the space following the words *due to* and should be stated in reverse order of occurrence from the immediate cause of death.

If there is more than one cause contributing to the death, the physician is expected to underline that particular ONE

cause to which, in his opinion, the death should be charged for purpose of statistical tabulation.

DEFINITION OF OTHER CONDITIONS:

Other conditions, existing coincidentally, which might have contributed to the risk of dying, but are not related to any clear-cut manner to the immediate or underlying cause of death, should be given under this item. Pregnancy within 3 months of death should be included because so many times causes of maternal death are missed unless this information is noted.

If operation or autopsy findings exist, the physician is requested to list the major conditions which have weight in deciding the underlying cause to which the death should be charged statistically.

For additional discussion of this subject see PHYSICIANS' HAND-BOOK ON BIRTH AND DEATH REGISTRATION issued by the U. S. Bureau of the Census. A copy of this booklet may be secured from the Baltimore City Health Department.

BUREAU V. S.

MAR 28 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

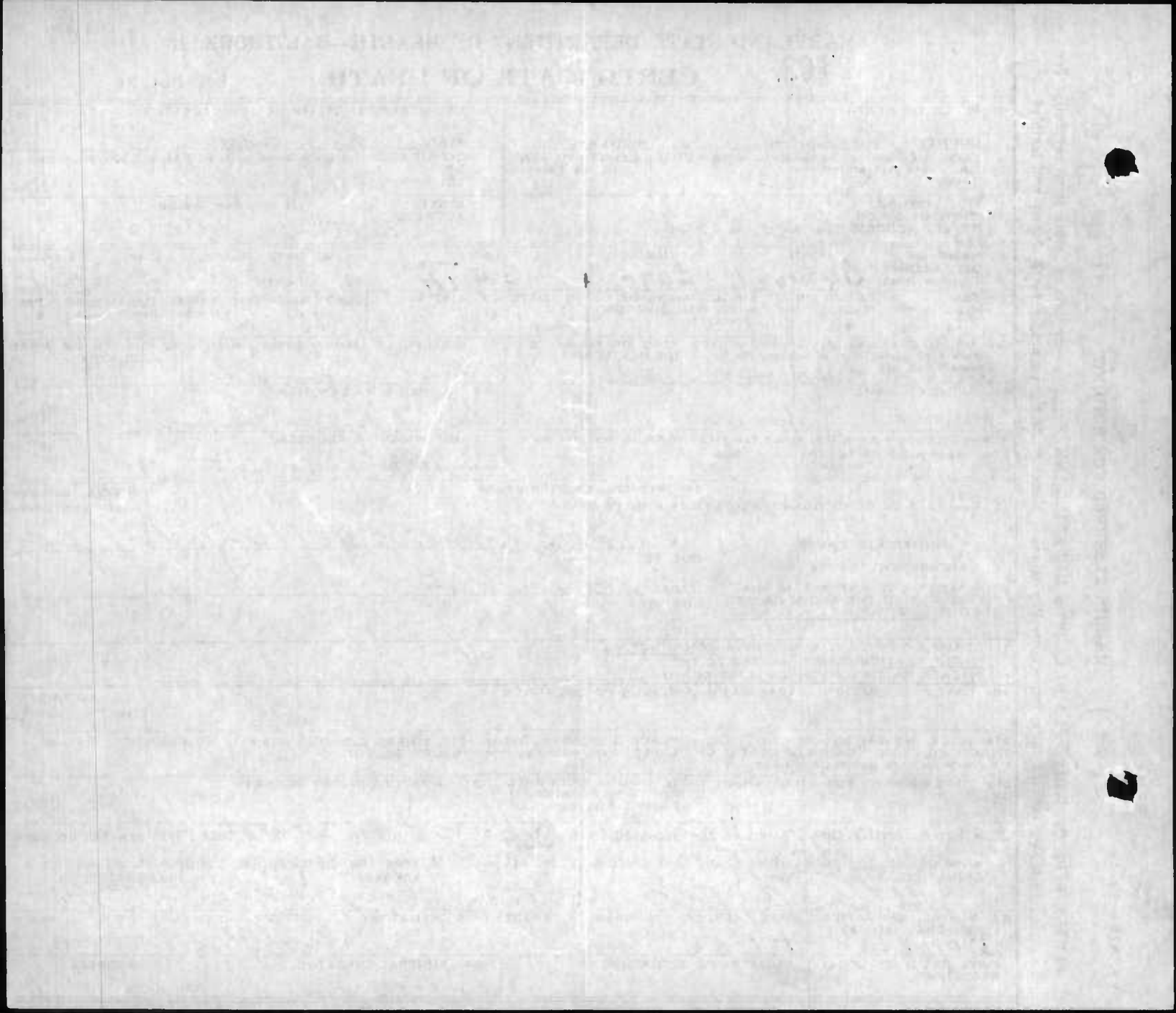
2463

CERTIFICATE OF DEATH

02447

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Balto.</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Bell...</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>X</i> TOWN <i>Hyde</i>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <i>X</i> TOWN <i>Hyde</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i> <i>Bretton Rd.</i>				STREET ADDRESS (If rural give location) <i>Bottom Rd</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Samuel Eugene Smith</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>Mar 28 1955</i>			
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: <i>Jan 29-1887</i>	9. AGE last birthday <i>68</i> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Retired oil distributor</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>oil</i>		11. BIRTHPLACE (State or foreign country): <i>Floyd Co - Georgia</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>James E. Smith</i>				14. MOTHER'S MAIDEN NAME: <i>Sarah Lulu Shores</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Russell J. Harris - Bottom Rd.</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
163X IMMEDIATE CAUSE		(A) <i>Carcinoma of right lung</i>					
ANTECEDENT CAUSE (S)		(B) <i>lung</i>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>Sept 5, 1954</i> to <i>Mar 25, 1955</i> , that I last saw the deceased alive on <i>Mar 25, 1955</i> , and that death occurred at <i>5 P</i> M, from the causes and on the date stated above.							
SIGNATURE <i>John M. Hammett</i>		M. D. <i>Baldwin</i>		ADDRESS <i>Mar 25-55</i>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>4-1-55</i>		NAME OF CEMETERY OR CREMATORY <i>Pleasant Hope Baptist</i>		LOCATION (City, town, or county) (State) <i>Floyd Co - Georgia</i>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS <i>Wm Cork Inc - 1217 St Paul St</i>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2464

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

02448

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> OR TOWN <u>15</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>6602 Mt. Vernon av., Balt.</u> OR TOWN <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6602 Mt. Vernon av.</u>		STREET ADDRESS (If rural give location) <u>6602 Mt. Vernon av.</u>	
3. NAME OF DECEASED (Type or Print) <u>John</u> (First) <u>T.</u> (Middle) <u>Snead</u> (Last)		4. DATE OF DEATH (Month) <u>March</u> (Day) <u>3</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>N</u>	8. DATE OF BIRTH <u>August 29, 1875</u>
9. AGE last birthday <u>81</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>	
11. BIRTHPLACE (State or foreign country) <u>Middlesex Co., Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John Thomas Snead</u>		14. MOTHER'S MAIDEN NAME <u>Mary</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
332X Immediate cause (a) <u>Cerebral Thrombosis</u>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Generalized arteriosclerosis</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Aneurysm, abdominal aorta</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 27</u> , 19 <u>54</u> , to <u>3 March</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>1 March</u> , 19 <u>55</u> , and that death occurred at <u>3:30 A</u> .m., from the causes and on the date stated above.			
SIGNATURE <u>Charles H. Williams, M.D.</u>		ADDRESS <u>Pikesville 8, Md.</u>	
DATE SIGNED <u>3 March '55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>Buried</u>		DATE THEREOF <u>3-5-55</u>	
NAME OF CEMETERY OR CREMATORY <u>Lorraine Memorial</u>		LOCATION (City, town, or county) <u>Woodlawn Md.</u>	
DATE REC'D BY LOCAL REG. <u>March 3, 1955</u>		REGISTRAR'S SIGNATURE <u>Howthyd. Newell</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newell</u>		ADDRESS <u>Pikesville, Md.</u>	

RECEIVED

MAR 7 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02449

2465 CERTIFICATE OF DEATH

Reg. Dist. No. 42

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Balt.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>X TOWN Fort Howard</u>		LENGTH OF STAY (in this place) <u>221 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR <u>TOWN Baltimore, 27 51</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>6907 Athol Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JOHN J. SOBIESKI</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>March 29, 19 55</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>5/18/99</u>	9. AGE last birthday <u>55</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Guard</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Maritime Comm.</u>		11. BIRTHPLACE (State or foreign country): <u>Krahov, Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>Pete Sobieski</u>				14. MOTHER'S MAIDEN NAME: <u>Katrine MN: Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>Yes WW-II Red</u>				16. SOCIAL SECURITY NO. <u>216-24-1599</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
203X IMMEDIATE CAUSE (A) <u>MULTIPLE MYELOMA</u>							
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
260X (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>DIABETES MELLITUS</u>						UNKNOWN	
19A. DATE OF OPERATION: <u>8/27/54</u>		19B. MAJOR FINDINGS ON OPERATION: <u>Findings: Plasma cell myeloma of bone. Laminectomy T-4 and Biopsy of Tumor</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA M.</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Aug. 20, 19 54</u> to <u>Mar. 29, 19 55</u> , that I last saw the deceased <u>5:45 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Francis G. Dickey</u>		M. D. <u>VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>3/30/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>4-2-55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Stanislaus Cemetery</u>		LOCATION (City, town, or county) (State) <u>Dundalk, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-30-55</u>		REGISTRAR'S SIGNATURE <u>R. W. Weber</u>		24. FUNERAL DIRECTOR <u>George Weber Funeral Home</u>		ADDRESS <u>105 S. Ann St., Balto., Md.</u>	

2466

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Baltimore	STATE	Maryland
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Fort Howard	COUNTY	Balto.
LENGTH OF STAY (in this place)	7 Days	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Baltimore, 4
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Veterans Administration Hospital	STREET ADDRESS (If rural give location)	8727 Eddington Road
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
RUSSELL S. SPRECHER		DEATH: March 23, 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:
Male	White	Widowed	July 8, 1893
9. AGE last birthday	10. BIRTHPLACE (State or foreign country):		
61 yrs.	Mt. Airy, Maryland		
11. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
U. S. A.		U. S. A.	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Charles G. Sprecher		Grace V. Harrison	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
Yes WW-I		Unknown	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
Clin. Rec., Vet. Adm. Hospital, Ft. Howard, Md.		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
IMMEDIATE CAUSE (A)		BLEEDING ABDOMINAL ANEURYSM	
ANTECEDENT CAUSE (S)		DUE TO	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B)	
		DUE TO	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		INTERVAL BETWEEN ONSET AND DEATH	
		7 DAYS	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
3-19-55		Aortic Graft	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from March 16, 1955, to March 23, 1955, and that death occurred at 11:45 M. from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
William B. VandeGrift, M. D.		M. D. VAH, Fort Howard, Maryland 3-24-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
Burial		Baltimore National Cemetery	
DATE REC'D BY LOCAL REGISTRAR		LOCATION (City, town, or county) (State)	
March 26, 1955		Baltimore, Maryland	
REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
R.W.		Wm. Cook-Blight Funeral Home	
		6009 Harford Road, Baltimore 14, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

WEST VIRGINIA STATE DEPARTMENT OF HEALTH
CERTIFICATE OF DEATH

1. Name of deceased: _____
2. Sex: _____
3. Age: _____
4. Date of birth: _____
5. Place of birth: _____
6. Date of death: _____
7. Place of death: _____
8. Cause of death: _____
9. Manner of death: _____
10. Signature of physician: _____
11. Signature of registrar: _____

12. Signature of informant: _____
13. Date of completion: _____
14. Registrar's office: _____
15. County: _____
16. State: _____

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2467

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Baltimore, 28</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>				STREET ADDRESS (If rural give location) <u>99 Dundalk Ave</u>			
3. NAME OF DECEASED: (First) <u>Homer</u> (Middle) <u>P.</u> (Last) <u>Squires</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>3</u> <u>8</u> <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Octob. 4 1876</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>HOME</u>		11. BIRTHPLACE (State or foreign country): <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>unknown</u>				14. MOTHER'S MAIDEN NAME: <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS: <u>CHLOE F. SIQUIRES - SAME ADDRESS</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Lobar Pneumonia</u>						5 days	
DUE TO							
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Arteriosclerotic heart disease</u>						years	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>4/6</u> , 19 <u>55</u> , to <u>3/8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/8</u> , 19 <u>55</u> , and that death occurred at <u>4:15 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Sheila Wachler</u>		ADDRESS <u>M. D. Spring Grove State Hospital</u>		DATE SIGNED <u>3/8/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>3-11-55</u>		NAME OF CEMETERY OR CREMATORY <u>MORELAND MEM. PK.</u>		LOCATION (City, town, or county) <u>BALTO. CO. Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/11/55</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		24. FUNERAL DIRECTOR <u>Walter Bush, 22, N. 1st</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAR 14 1995

RECEIVED

MARYLAND

STATE DEPARTMENT OF HEALTH

02452

2468

CERTIFICATE OF DEATH

Reg. Dist. No. 38

Item 9, Film G179 4-5-55 et

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD.</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>BROOKLANDVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLANDVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>VILLA JOSE</u>		STREET ADDRESS (If rural, give location) <u>VALLEY ROAD.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>SISTER MARIE MARTINA STANKARD</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 20, 1955</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>OCT. 24, 1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TEACHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RELIGIOUS</u>	9. AGE last birthday <u>48</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>MASS.</u>	
13. FATHER'S NAME <u>MARTIN STANKARD</u>		14. MOTHER'S MAIDEN NAME <u>MARY JOSEPHINE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>115 0 000 81</u>	
17. INFORMANT AND ADDRESS <u>Valley Road - Valley Rd.</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>201X</u> Immediate cause (a)..... <u>Hodgkins Disease</u> Antecedent cause(s) (b)..... Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....		INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Ap</u> , 19 <u>53</u> , to <u>March</u> 19 <u>55</u> , that I last saw the deceased alive on <u>Mar 19</u> , 19 <u>55</u> , and that death occurred at <u>4:15A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Harold H Burns</u>		DATE SIGNED <u>3/21/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Trinity Convent Cem.</u>	
DATE <u>3-22-55</u>		LOCATION (City, town, or county) (State) <u>Ellicott, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>3/31/55</u>		24. FUNERAL DIRECTOR <u>Valley Funeral Home, Catonsville, Md.</u>	

Burns

BUREAU V. S.

APR 1 1955

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No. 38

2469

I. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	
X TOWN <u>Stonelaugh</u>			X
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
<u>807 Kingston Road</u>		<u>807 Kingston Rd.</u>	
3. NAME OF DECEASED: (Type or Print)	(First) (Middle) (Last)	4. DATE OF DEATH: (Month) (Day) (Year)	
<u>Lois Biddle Stephens</u>		<u>March 3, 1955</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>FEMALE</u>	<u>White</u>	<u>Single</u>	<u>Nov. 20, 1900</u>
9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>54</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
<u>Teacher</u>	<u>High School</u>	<u>Kansas City, Mo.</u>	
13. FATHER'S NAME:	14. MOTHER'S MAIDEN NAME:		
<u>Dr. Herbert Taylor Stephens</u>	<u>Emma West Johnston</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	16. SOCIAL SECURITY No.:	17. INFORMANT & ADDRESS:	
		<u>Mrs. James L. Sudborough 807 Kingston Rd.</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

175X Immediate cause (a) Intestinal obstruction

Antecedent cause(s) (b) Carcinoma of the ovary

Diseases or conditions, if any, giving rise to the above cause, stating underlying cause last

(c) none

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

August 27, 1953 Carcinoma of left ovary with metastases

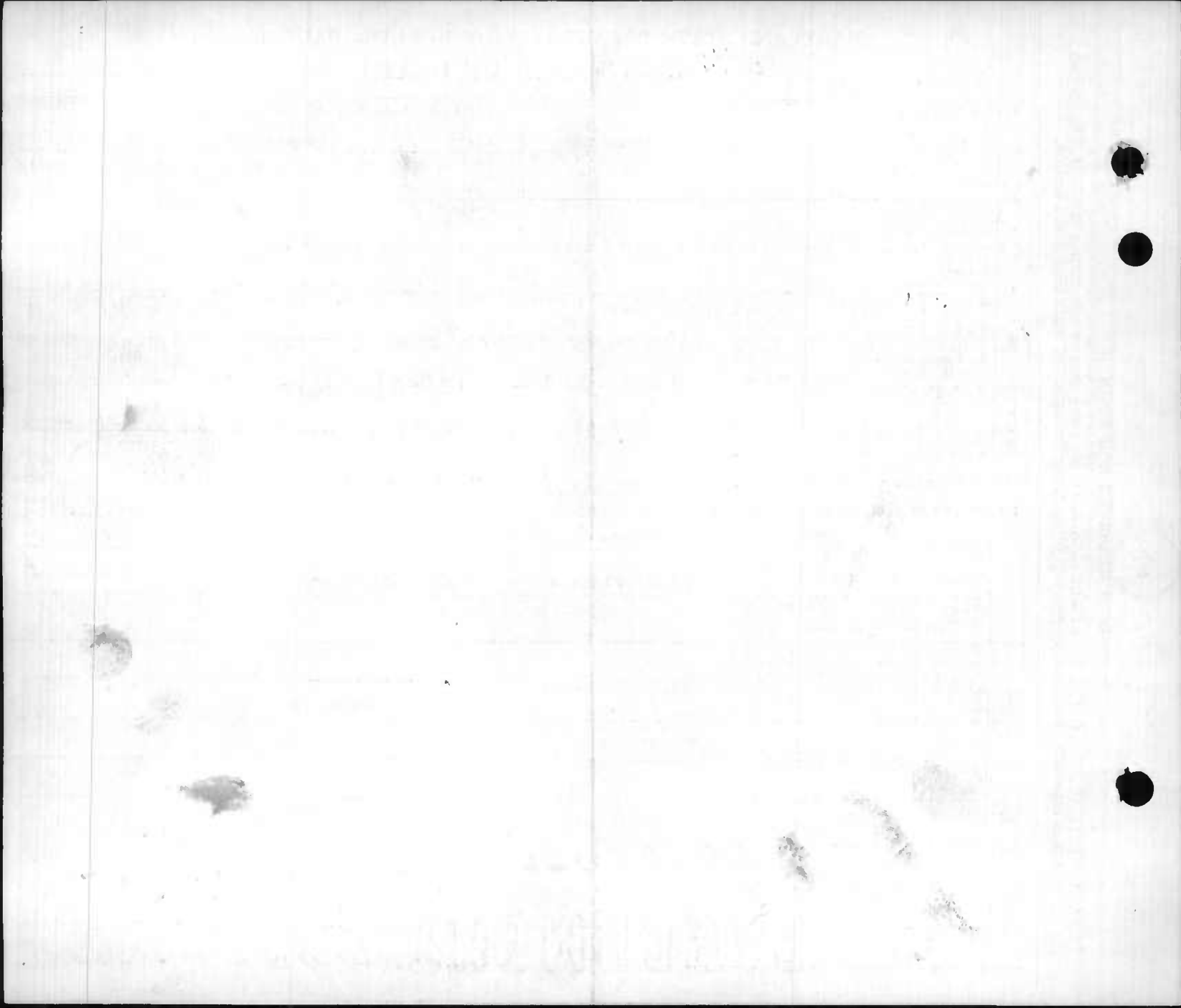
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
<u>none</u>	<u>INJURY</u>			
TIME (Month) (Day) (Year) (Hour)	INJURY OCCURRED	HOW DID INJURY OCCUR?		
OF INJURY	While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			

22. I hereby certify that I attended the deceased from August 5, 1953, to March 3, 1955, that I last saw the deceased alive on March 3, 1955, and that death occurred at 9:10 A.M., from the causes and on the date stated above.

SIGNATURE	(DEGREE OR TITLE)	ADDRESS	DATE SIGNED
<u>A.S. Chabaut, M.D.</u>		<u>6210 York Road</u>	<u>March 3, 1955</u>
23. BURIAL, CREMATION REMOVAL (Specify):	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>BURIAL</u>	<u>March 5, 1955</u>	<u>Druid Ridge</u>	<u>Pikesville, Md.</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3/3/55</u>	<u>A.W. Hedrick</u>	<u>John O. Mitchell & Sons</u>	<u>1900 Eutaw Rd.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2317

02454

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 41

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>md</u>	COUNTY <u>Balto.</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Baltimore</u>	LENGTH OF STAY (in this place) <u>1 year.</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Dundalk</u>	<u>22</u> <u>53</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1834 Portship Road</u>		STREET ADDRESS <u>1834 Portship Rd.</u>	
3. NAME OF DECEASED: (First) <u>Kenneth</u> (Middle) <u>Earl</u> (Last) <u>Stevens</u>		4. DATE OF DEATH (Month) <u>Mar</u> (Day) <u>28</u> (Year) <u>1955</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (State)	8. DATE OF BIRTH: <u>June 9/1908</u>
		9. AGE last birthday: <u>46</u> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Accountant</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>City Hospital</u>	11. BIRTHPLACE (State or foreign country): <u>Amburidge Pa</u>
13. FATHER'S NAME: <u>Stefred Stevens</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Reiningier</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>No</u> (If Yes, give war or dates of service) -----		16. SOCIAL SECURITY No.: <u>169-05-6104</u>	
		17. INFORMANT & ADDRESS: <u>Geneva Stevens-1834 Portship-Dundalk</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH <u>15 min.</u>
<p>420.1 Immediate cause (a) <u>Coronary occlusion</u> DUE TO</p> <p>Antecedent cause(s) (b) ----- DUE TO</p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) -----</p>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF <u>APRIL 3-28-55 2 P.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>W. M. Barmine</u> M.D.		DATE SIGNED <u>3/28/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>3/30/55</u>	
NAME OF CEMETERY OR CREMATORY <u>Sacred Heart</u>		LOCATION (City, town, or county) (State) <u>Baltimore 22, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <u>March 28-1955 William M. Kelly</u>		24. FUNERAL DIRECTOR <u>Walter Brooks Bradley, Inc.</u> ADDRESS <u>Dundalk 22 Maryland</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAR 30 1955

BUREAU V. S.

2470

CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH: Towson			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Baltimore		MARYLAND		STATE Maryland COUNTY	
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) 55 TOWSON		LENGTH OF STAY (in this place) 1 yr. 9 mos. 25 d.		CITY (If outside corporate limits, write RURAL and give nearest town) 3 V01-4 TOWN Baltimore	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 13 Sheppard & Enoch Pratt Hosp. Towson 4, Maryland		STREET ADDRESS (If rural give location) 101 W. Monument St.			
3. NAME OF DECEASED: (First) Margaret (Middle) Talbot (Last) Stevens			4. DATE OF DEATH: (Month) 3 (Day) 30 (Year) 1955		
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: Feb. 6, 1892		9. AGE last birthday: 63 yrs. Months Days Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Librarian		10b. KIND OF BUSINESS OR INDUSTRY: B. & O. Rail Road		11. BIRTHPLACE (State or foreign country): Anne Arundel Co., Md.	
13. FATHER'S NAME: Thomas Eddy Stevens			14. MOTHER'S MAIDEN NAME: Id. Isabel Talbot		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: Hospital records	

18. MEDICAL CERTIFICATION			Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
355X Immediate cause (a) Broncho pneumonia DUE TO Antecedent causes (s) (b) Diffuse cerebral atrophy Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) (Cause unknown) DUE TO			1 term 2 yr +
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Chronic Brain Syndrome of Unknown origin & psychosis			2 yr +
19a. DATE OF OPERATION:	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

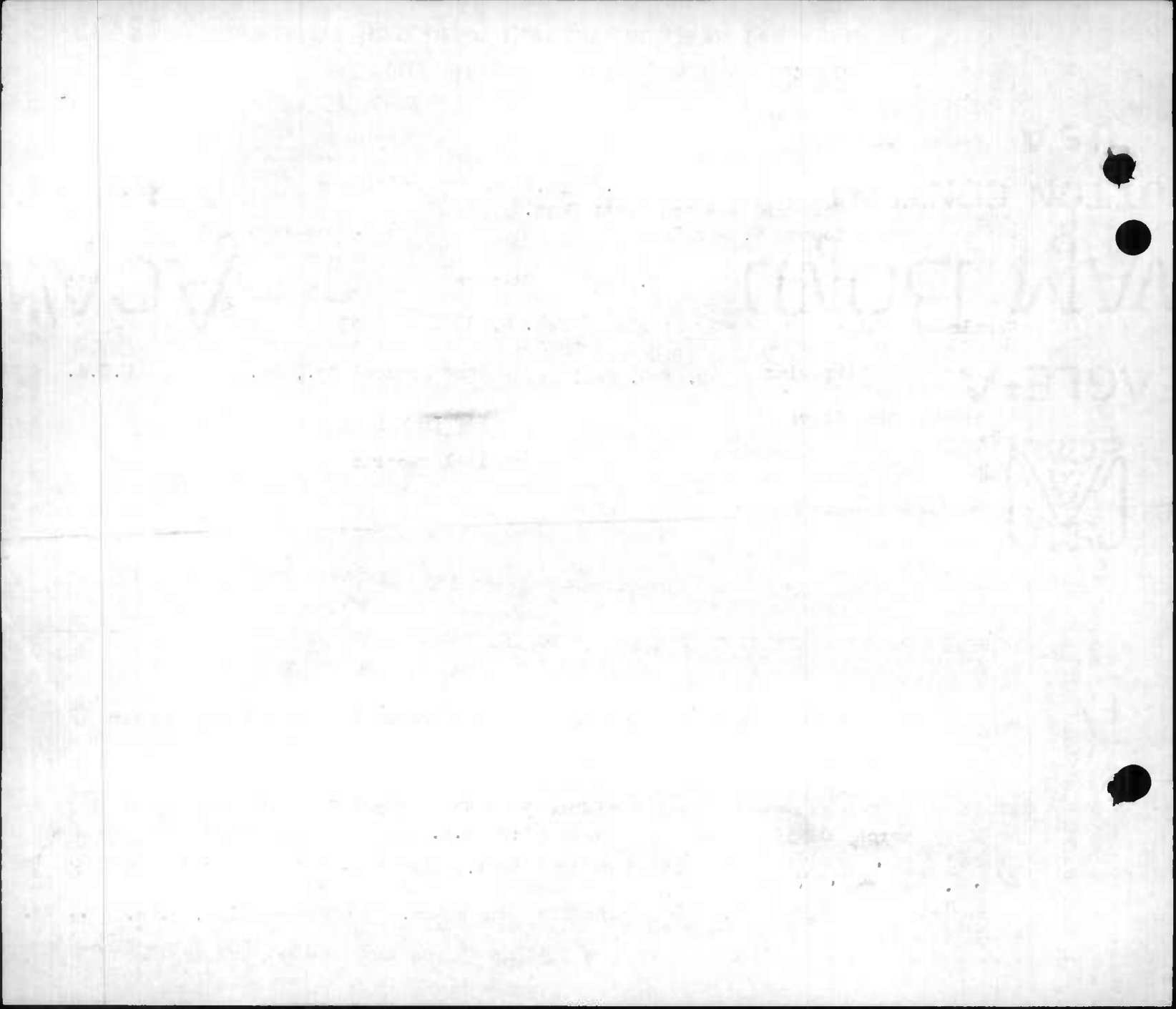
22. I hereby certify that I attended the deceased from **June 5, 1953**, to **March 30, 1955**, that I last saw the deceased

alive on **March 30, 1955**, and that death occurred at **3:00 p.m.**, from the causes and on the date stated above.

SIGNATURE W. Edgar M. D.		DATE SIGNED 3/30/55	
ADDRESS Assistant Medical Supt., Sheppard-Pratt Hospital			
23. BURIAL, CREMATION, REMOVAL (Specify) Burial	DATE THEREOF April 2, 1955	NAME OF CEMETERY OR CREMATORY Methodist Church Cem.	LOCATION (City, town, or county) (State) Davidsonville, A. A. Co., Md.
DATE REC'D BY LOCAL REGISTRAR 3-31-55	REGISTRAR'S SIGNATURE A. A. Hedrick	FUNERAL DIRECTOR John D. Mitchell & Sons Inc. 1900 Eutaw Place	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2471

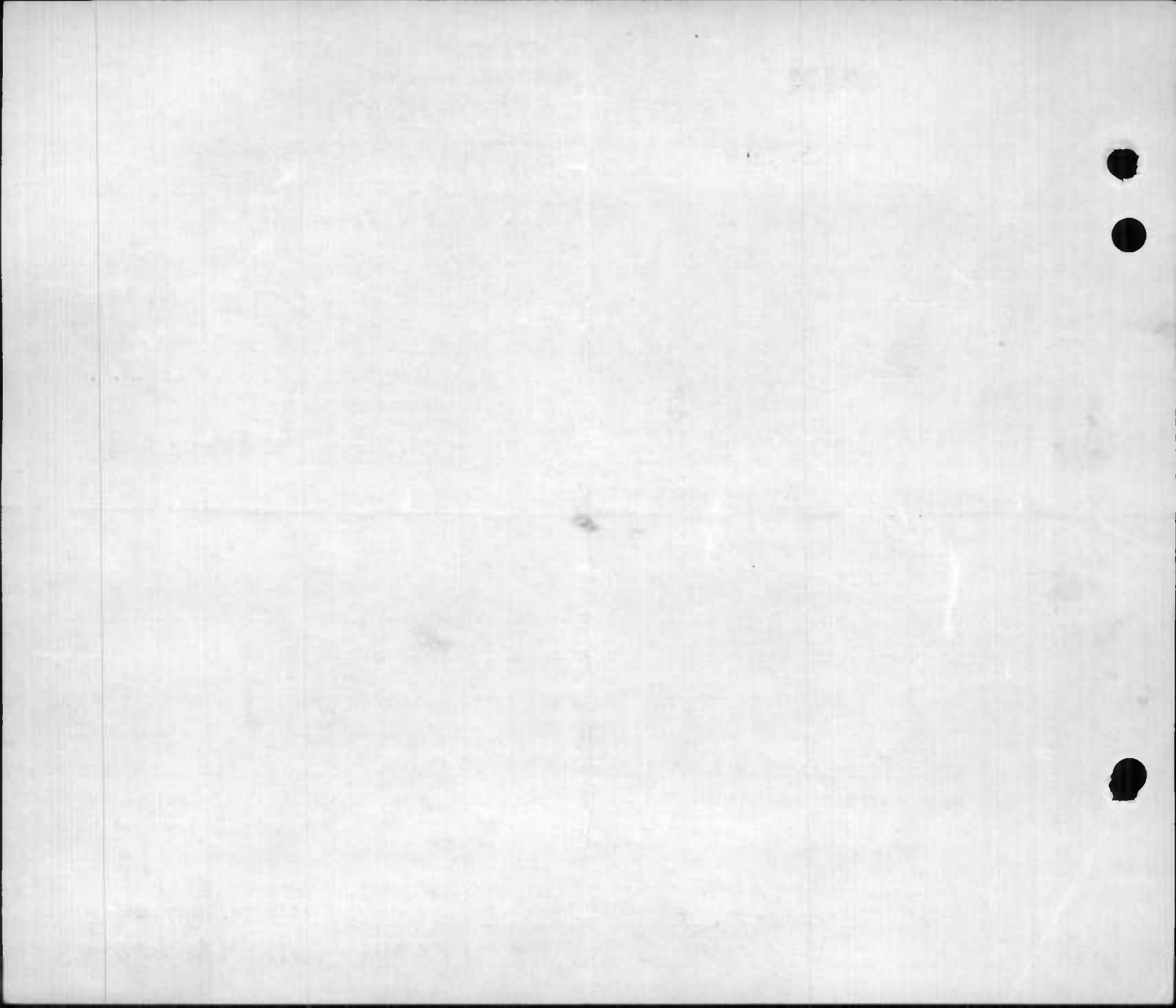
2411 N. Charles Street, Baltimore

02456

CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overlea</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Overlea, Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>701 Elmwood Road</u>		STREET ADDRESS (If rural, give location) <u>701 Elmwood Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Elizabeth</u>	(Middle) <u>A.</u>	(Last) <u>Streb</u>
4. DATE OF DEATH	(Month) <u>March</u>	(Day) <u>17</u>	(Year) <u>1955</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>Dec. 13, 1874</u>
9. AGE last birthday <u>80</u> yrs.	If under 1 year Months <u> </u> Days <u> </u>	If under 24 hrs. Hours <u> </u> Min. <u> </u>	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>
10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Joseph Krastel</u>	14. MOTHER'S MAIDEN NAME <u>Catherine Bunn</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>Robert J. Streb 701 Elmwood Road</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>331X Immediate cause</u> <u>Antecedent cause(s)</u> <u>cerebral hemorrhage</u> <u>with osleria</u>			INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Sept 19 53</u> , to <u>March 17 55</u> , that I last saw the deceased alive on <u>March 17 55</u> , and that death occurred at <u>5 P.m.</u> , from the causes and on the date stated above. SIGNATURE <u>[Signature]</u> DATE SIGNED <u>3-18-55</u> <u>H.D.</u>			
23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>March 21, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Holy Redeemer</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REG-18	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR ADDRESS <u>Lilly & Zeiler Inc., 403 S. Wolfe St.</u>	



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

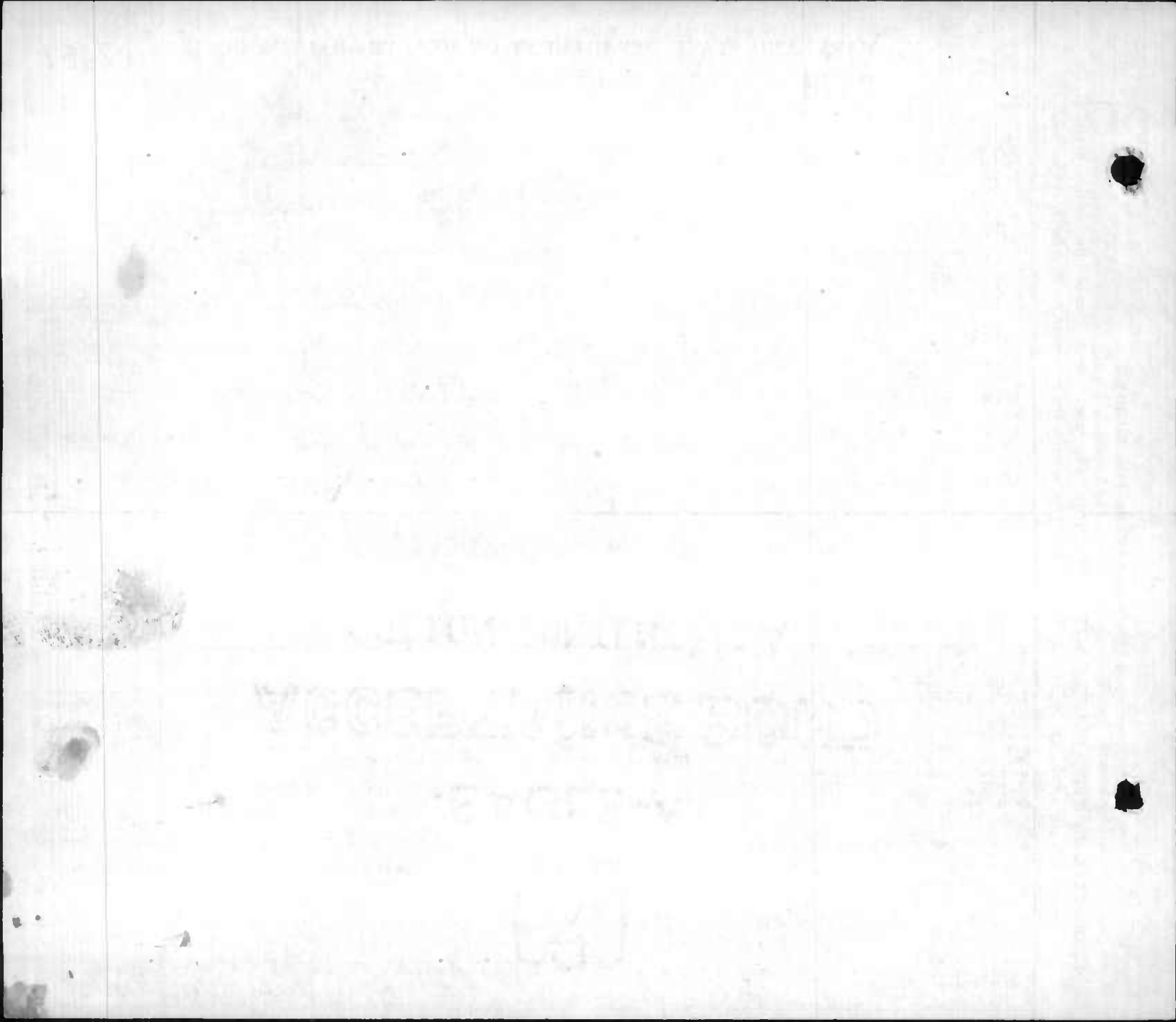
02457

2472

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		X	
X TOWN <u>Woodlawn</u>				TOWN <u>Woodlawn</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>911 Masfield Rd.</u>				STREET ADDRESS (If rural give location) <u>911 Masfield Rd.</u>			
3. NAME OF DECEASED: (First) <u>M.</u>		(Middle) <u>ETHEL</u>		(Last) <u>STROM</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar.</u> <u>4.</u> <u>19 55</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>May 24, 1891</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Teacher</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Nursery School</u>		11. BIRTHPLACE (State or foreign country): <u>Ill.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Henry S. Noble</u>				14. MOTHER'S MAIDEN NAME: <u>Annie McGhee</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Mr. Harry G. Neuman-911 Masfield Rd. #7</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial infarction</u>						<u>10 min.</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerotic heart disease</u>						<u>10 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Malignant hypertension</u>						<u>10 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>May 25, 1954</u> , to <u>March 3, 1954</u> , that I last saw the deceased alive on <u>March 3, 1954</u> , and that death occurred at <u>3:25 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Stephen J Van Lill Jr</u>		ADDRESS <u>M.D. 2843 St Paul</u>		DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>3/7/55</u>		NAME OF CEMETERY OR CREMATORY <u>National Mem. Pk.</u>		LOCATION (City, town, or county) (State) <u>Balls Church, Va.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-4-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		FUNERAL DIRECTOR <u>[Signature]</u>		ADDRESS <u>Balto 17 Md</u>	



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2473

02458

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Catonsville</u>	LENGTH OF STAY (In this place) <u>6yr. 5mo. 14days</u>	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	<u>516 S. Hanover St.</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>	STREET ADDRESS <u>Seton Institute</u>	(If rural, give location) <u>3401-4</u>	
3. NAME OF DECEASED: (Type or Print)	(First) <u>Anton</u>	(Middle)	(Last) <u>Sulovsky</u>
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>5-27-1889</u>
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Czechoslovakia</u>
13. FATHER'S NAME: <u>Jon Sulovsky</u>		14. MOTHER'S MAIDEN NAME: <u>Anna Parfreakova</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY No.: <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>		18. MEDICAL CERTIFICATION	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH
<p>429.1 Immediate cause (a) <u>Pericardial Tamponade due to</u></p> <p>Antecedent cause(s) (b) <u>Ruptured heart, Arterio sclerotic coronary</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>heart disease</u></p>		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .		
SIGNATURE <u>Dr. M. Kieffer</u> 1010 Leids		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>Mar 16 55</u>
DEPUTY MEDICAL EXAMINER		ASSISTANT MEDICAL EXAM.
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF <u>Mar. 19/55</u>	NAME OF CEMETERY OR CREMATORY <u>St. Peter's Cem.</u>
LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	24. FUNERAL DIRECTOR <u>Harry H. Witzke</u>	ADDRESS <u>4101 Edmondson Ave.</u>
DATE REC'D BY LOCAL REG. <u>3/19/55</u>	REGISTRAR'S SIGNATURE <u>V. E. Harry</u>	

BUREAU V. S.

MAR 22 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02459

Reg. Dist. No. 43

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Baltimore</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7012 Beach Ave</u>		STREET ADDRESS (If rural, give location) <u>7012 Beach Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Carrie M Taaffe</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>March 16 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Aug 22-1892</u>
9. AGE last birthday <u>62</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Balto City md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Otto H Guertel</u>		14. MOTHER'S MAIDEN NAME <u>Lena Roehn</u>	
15. WAS DECREASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mr Leopold T. Taaffe 7012 Beach Ave</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
345 X Immediate cause (a) <u>Cardio Respiratory Collapse</u>	<u>4 days</u>
Antecedent cause(s) (b) <u>Multiple Sclerosis</u>	<u>year</u>
(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June, 1954, to March 16, 1955, that I last saw the deceased alive on 3-15, 1955, and that death occurred at 8 A m., from the causes and on the date stated above.

SIGNATURE: William L. Feunig MD ADDRESS: 3025 Belair Road DATE SIGNED: 3-16-55

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>Funeral Home</u>	<u>3/19/55</u>	<u>Parkview Cem</u>	<u>Balto Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>3-19-55</u>	<u>John J. Hahn</u>	<u>Classical Funeral Home</u>	<u>7401 Belair Rd</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3025 Belair Rd

Dr. Fearing

02460

2475
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balt.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balt.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
<input checked="" type="checkbox"/> TOWN <u>Pikesville</u>		<u>12 yrs</u>		<input checked="" type="checkbox"/> TOWN <u>Pikesville</u>			
HOSPITAL, OR INSTITUTION OR STREET ADDRESS <u>4105 Lowell Drive</u>				STREET ADDRESS <u>4105 Lowell Drive</u> (If rural, give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>PERCY BROWNE THOMAS</u>				<u>Mar 6 1955</u>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<u>male</u>		<u>W.</u>		<u>Widowed</u>		<u>Jan 11, 1895</u>	
						<u>60 yrs.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>auditor</u>		<u>Md. Casualty</u>		<u>Balt. Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Frank F. Thomas</u>				<u>Olivia Browne</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>No.</u>		<u>None</u>		<u>Kindred C. Apt. Eugene D. Thomas (brother)</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
<u>420.1</u> Immediate cause (a) <u>Coronary Artery Disease</u>						<u>5 mo.</u>	
DUE TO							
Antecedent cause(s) (b) _____							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) _____							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>None.</u>							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
<u>None.</u>		<u>None.</u>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)			
<u>No.</u>		<u>None</u>		<u>None</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>None. M.</u>		<u>None</u>		<u>None.</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.							
SIGNATURE		CHIEF MEDICAL EXAMINER					
<u>D. D. Caples</u>		DEPUTY MEDICAL EXAMINER					
		ASSISTANT MEDICAL EXAM.					
		DATE SIGNED					
		<u>3-6-55</u>					
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Cremation</u>		<u>3/9/55</u>		<u>Loudon Park Cem.</u>		<u>Balto., Md.</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-7-55</u>		<u>W. J. Hedrick</u>		<u>Wm. J. Tidwell & Sons</u>		<u>Balt. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

WATER RESOURCES DIVISION

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UNITED STATES DEPARTMENT OF THE INTERIOR
BUREAU OF LAND MANAGEMENT

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

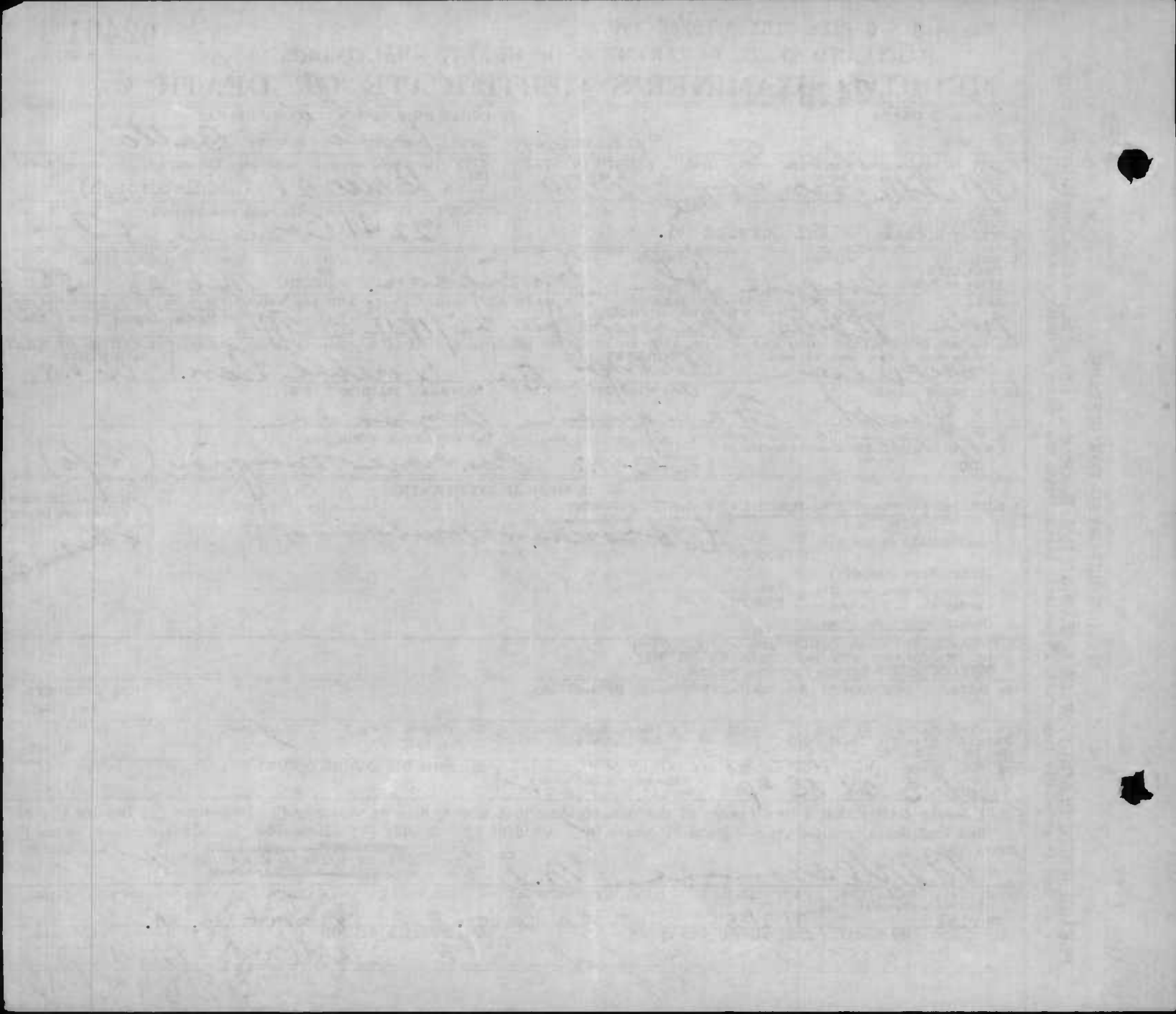
MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 44

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto.</u>	MARYLAND	STATE <u>Balto</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write name of town and give nearest town) <u>North Baltimore</u>	LENGTH OF STAY (If this place) <u>8 yrs</u>	CITY (If outside corporate limits write RURAL and give nearest town) <u>Balto 21 (Middleborough)</u>	TOWN <u>Balto 21 (Middleborough)</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>2241 Corsica Rd.</u>		STREET ADDRESS (If rural, give location) <u>2241 Corsica Rd.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Eugene</u> (Middle) <u>John</u> (Last) <u>Toussignon</u>		(Month) <u>Mar</u> (Day) <u>28</u> (Year) <u>1955</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>1902</u> AGE last birthday: <u>53</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>aircraft</u>	11. BIRTHPLACE (State or foreign country): <u>Quebec Can.</u>
12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>		13. FATHER'S NAME: <u>Joseph Toussignon</u>	
14. MOTHER'S MAIDEN NAME: <u>Amanda</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) <u>no</u> (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No.: <u>213-03-9992</u>		17. INFORMANT & ADDRESS: <u>Mrs. Irene Toussignon (info)</u>	

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary occlusion</u> DUE TO					
Antecedent cause(s) (b) <u></u> DUE TO					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u></u>					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>March 3 28 55 pm</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE: <u>Wm. J. Tickeney</u> M.D.		DEPUTY MEDICAL EXAMINER: <u>Wm. J. Tickeney</u> M.D.		DATE SIGNED: <u>5/17/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>3/31/55</u>		NAME OF CEMETERY OR CREMATORY: <u>Druid Ridge Cem.</u>	
LOCATION (City, town, or county) (State): <u>Pikesville, Md.</u>		24. FUNERAL DIRECTOR: <u>Wm. J. Tickeney & Sons</u>		ADDRESS: <u>Balto 17 Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. 33-

2477

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Rural - Millers</u>		<u>30yrs.</u>		TOWN <u>Rural - Millers</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Beckleysville Rd.</u>				STREET ADDRESS (If rural give location) <u>Beckleysville Rd.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
First <u>Harry</u> (Middle) (Last) <u>Tracey.</u>				DATE <u>March 9, 1955</u>			
5. SEX: <u>Male</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>August 6, 1872</u>	
9. AGE last birthday <u>82</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Farm.</u>		11. BIRTHPLACE (State or foreign country): <u>Beckleysville, Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME: <u>Jacob Tracey.</u>		14. MOTHER'S MAIDEN NAME: <u>Martha Egglinson.</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>	
16. SOCIAL SECURITY No. <u>331X</u>		17. INFORMANT & ADDRESS: <u>Mrs. Ethel Tracey - Millers</u>		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

IMMEDIATE CAUSE

(A)

DUE TO

ANTECEDENT CAUSE (S)

(B)

DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19A. DATE OF OPERATION: 19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? YES ☐ NO ☒

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/8, 1955, to 3/9, 1955, that I last saw the deceased alive on 3/9/55, 1955, and that death occurred at 11:30 PM, from the causes and on the date stated above.

SIGNATURE

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (SPECIFY)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

BUREAU V. S.

MAR 21 1955

RECEIVED

2478

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Queen Anne's</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Lutherville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Centerville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor Nursing Home</u>		STREET ADDRESS (If rural give location)	

3. NAME OF DECEASED: (Type or Print) <u>Agatha Wheeler Vest</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>March 22 19 55</u>		
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Oct. 10, 1864</u>	9. AGE last birthday: <u>90</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>Mississippi</u>	
13. FATHER'S NAME: <u>John Emory</u>			14. MOTHER'S MAIDEN NAME: <u>Mary Conway Emmanuel</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <u>Washington, D.C.</u> <u>Mr. John. P. W. Vest - 1627 K St. N. W.</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>		<u>5 year ?</u>
ANTECEDENT CAUSE (B) <u>Hypertension Cerebrovascular disease</u>		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 3/18, 1955, to 3/22, 1955, that I last saw the deceased alive on 3/21, 1955, and that death occurred at 10:55 PM, from the causes and on the date stated above.

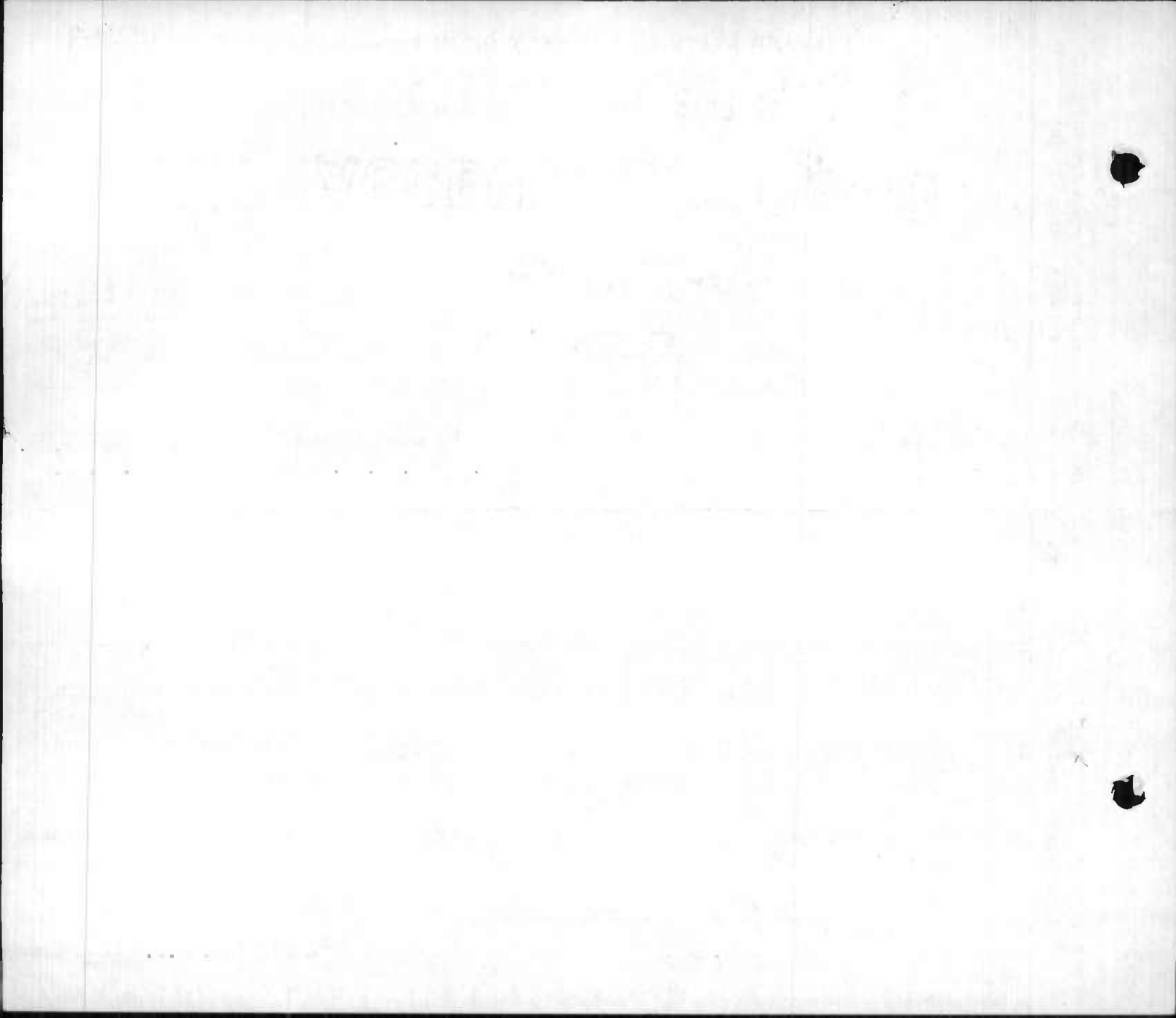
SIGNATURE George S. Watson ADDRESS 1104 St. Paul St. Balt. Md. DATE SIGNED 3/23/55

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal DATE THEREOF March 23, 1955 NAME OF CEMETERY OR CREMATORY Washington, D.C. LOCATION (City, town, or county) (State)

DATE REC'D BY LOCAL REGISTRAR 3-23-55 REGISTRAR'S SIGNATURE A. W. Hyland FUNERAL DIRECTOR'S SIGNATURE Wm. J. Lickner & Sons - Balt. Md. ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02464

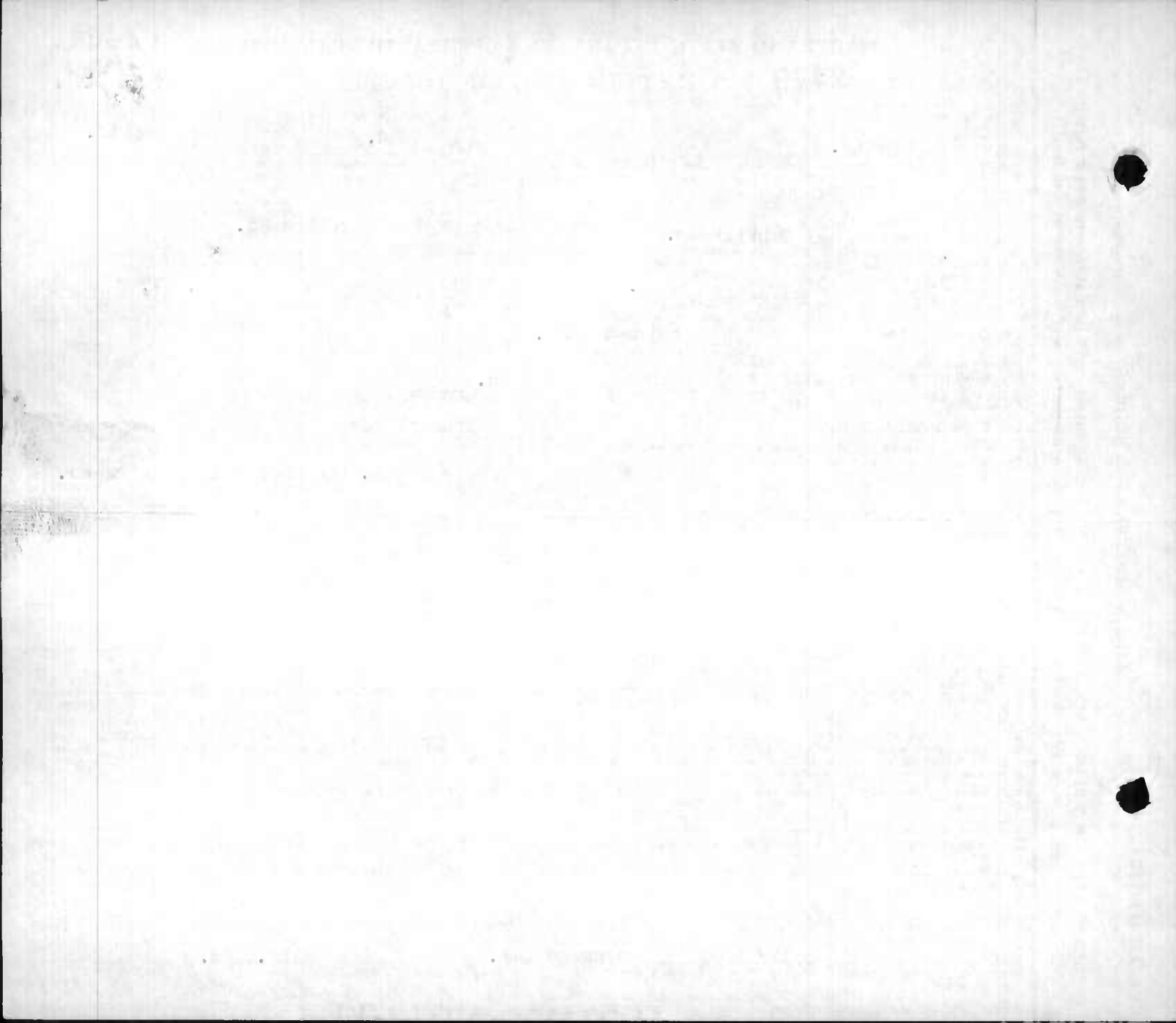
2479

CERTIFICATE OF DEATH

Reg. Dist. No.

38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>55</u> TOWN <u>Towson</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Towson</u> <u>55</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>100</u> <u>41 Dunkirk Rd.</u>				STREET ADDRESS (If rural give location) <u>1</u> <u>41 Dunkirk Rd.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>OLLIE</u> <u>M.</u> <u>VISSMAN</u>				DATE OF DEATH: <u>Mar. 17,</u> <u>19 55</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>female</u>	<u>white</u>	<u>widowed</u>	<u>Oct. 7, 1876</u>	<u>78</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME: <u>George Knellinger</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Bush</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>none</u>			
17. INFORMANT & ADDRESS: <u>Miss Ethel I. Viessman - 41 Dunkirk Rd.</u>							
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>422.1</u> <u>Cardiovascular disease</u>							<u>about 5 1/2</u>
ANTECEDENT CAUSE (B) <u>Arteriosclerosis</u>							<u>9</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 4</u> , 19 <u>54</u> , to <u>March 17</u> , 19 <u>55</u> that I last saw the deceased alive on <u>Dec March 7</u> , 19 <u>55</u> , and that death occurred at <u>9³⁰</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Phyllis Stillitt</u>		ADDRESS <u>2220 Barrim Blvd</u>		DATE SIGNED <u>Oct 18 1955</u>			
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/19/55</u>		<u>Parkwood Cem.</u>		<u>Balto., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		FUNERAL DIRECTOR		ADDRESS	
<u>3-18-55</u>		<u>[Signature]</u>		<u>Wm. J. Tiekner & Sons</u>		<u>Balto., Md.</u>	



2318

MARYLAND STATE DEPARTMENT OF HEALTH

02465

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

Item 9, File G179 3-24-55 et

1. PLACE OF DEATH -
COUNTY

Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL and

53

OR give nearest town)

TOWN

Dundalk 22

LENGTH OF STAY

(in this place)

5 wks

HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

00

100 BARBERRY CT

2. USUAL RESIDENCE (HOME) OF DECEASED -
STATE

Maryland

COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR

TOWN

Baltimore

3101-4

STREET

ADDRESS

(If rural, give location)

633 St. Mulberry St

3. NAME OF
DECEASED
(Type or Print)

(First)

OTIS

(Middle)

Hebsten

(Last)

Halken

4. DATE

OF

DEATH

(Month)

March

(Day)

17

(Year)

1955

5. SEX

Male

6. COLOR OR RACE

Colored

7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify)

Married

8. DATE OF BIRTH

May 10, 1893

9. AGE last birthday

61

yrs.

If under 1 year

Months

Days

Hours

Mins.

If under 24 hrs.

10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

Store Clerk

10b. KIND OF BUSINESS OR
INDUSTRY

Sea Food Place

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT
COUNTRY

U.S.

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)

yes

16. SOCIAL SECURITY No.
(If yes, give war or dates of
service)

1st: 8/1/42

17. INFORMANT AND ADDRESS

MRS. MARIAN E. WALKER, 100 BARBERRY CT, DUNDALK 22 MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) Hypostatic Pneumonia

Antecedent cause(s)

Diseases or conditions, if any,
giving rise to the above cause,
stating the underlying cause last

(b) Cerebral Apoplexy

(c)

INTERVAL BETWEEN
ONSET AND DEATH

2 days

1 yr

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)

INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)

OF
INJURYINJURY OCCURRED
While at Not While
Work ☐ At work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from February 10, 1955, to March 17, 1955, that I last saw the deceased

alive on March 17, 1955, and that death occurred at 10:28 a.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

William C. Shade M.D.

140 Oak Avenue, Dundalk 22 Md 3/17/55

23. BURIAL, CREMATION
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

3/21/55

Balto. National

Baltimore, Md.

DATE REC'D BY LOCAL
REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MAR 18 1955

L R

Charles R. Law, 802 Madison Ave

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



2480

CERTIFICATE OF DEATH

Reg. Dist. No. 105

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Charles	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN Owings Mills		1 yr. 4 mo.		TOWN (Rural) Potomac Heights		08-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
12 Rosewood State Training School				10 Kenwood Place			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
(Type or Print)		Michael Paul Weeks		3 27 19 55			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
male	white	single	8/12/47	7 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				LaPlata, Maryland		U.S.A.	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Milton A. Weeks				Ruby Elizabeth Byrd			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
				Rosewood Records, Owings Mills, Maryland			

18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							Interval Between Onset And Death
492X Immediate cause (a) an Aspiration Pneumonitis							2-3 days
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO							
(c)							
11. OTHER SIGNIFICANT CONDITIONS Congenital malformation of brain with mental deficiency, flacid paralysis and convulsive							
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION congenital disorder					
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION congenital disorder					
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work Not While At Work		HOW DID INJURY OCCUR?			
3 27 55 m.		Work					
22. I hereby certify that I attended the deceased from 11/5/19. 53, to 3/27/19. 55, that I last saw the deceased alive on 3/27/19. 55, and that death occurred at 12:45 p.m., from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
Viola B. Johns		M.D.		Owings Mills, Maryland		3/28/55	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		3-30-55		Marbury Baptist		Marbury Md	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
3-30-55		Mary Elinor		Francis P. Ryan		Bladell Md	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

APR 1 1965

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 02467

2481 CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>Glyndon (Rural)</u>		20 yrs.		TOWN <u>Glyndon (Rural)</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>Worthington Rd.</u>				<u>Worthington Rd.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year) OF DEATH:			
(First) (Middle) (Last) <u>John Evan Wheeler</u>				<u>3-23-55</u> 19			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
male		white		married		<u>3-27-1901</u>	
						53 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>groom</u>		<u>horse farm</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Evan D. Wheeler</u>				<u>Ida Skipper</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
no.				<u>215-16-0040</u>		<u>Mrs. Dora Agnes Wheeler, Glyndon, Md.</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE						(A) <u>Cardiac Decompensation</u> 10 mo.	
ANTECEDENT CAUSE (S)						DUE TO <u>arteriosclerotic C.-V. Disease</u> 2 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(B) <u>Left Bundle Branch Block.</u> 10 mo.	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						9 days.	
19A. DATE OF OPERATION:						19B. MAJOR FINDINGS OF OPERATION	
<u>none.</u>						<u>none.</u>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		<u>none.</u>		<u>none.</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21F. HOW DID INJURY OCCUR?			
<u>none.</u> M.		<u>none.</u>		<u>none.</u>			
22. I hereby certify that I attended the deceased from <u>12-3</u> , 19 <u>51</u> , to <u>3-23</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3-22</u> , 19 <u>55</u> , and that death occurred at <u>3 P. M.</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>D. D. Caples</u>		<u>Reisterstown, Md.</u>		<u>3-24-55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3-26-55</u>		<u>Black Rock</u>		<u>Butler, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>3-26-55</u>		<u>May B. Elina</u>		<u>Brooks Funeral Service, Sparks, Md.</u>		<u>I. Scott Brooks</u>	

BUREAU V. S.

MAR 30 1955

RECEIVED

2482

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY		Baltimore		STATE		Maryland	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		Fort Howard		COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN		Fort Howard		TOWN		622 Lee Street	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		Veterans Administration Hospital		STREET ADDRESS		622 W. Lee Street	
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First)		(Middle)		(Last)		(Month) (Day) (Year)	
JAMES		E.		WHITE		March 28 1955	
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
Male		Colored		Married		March 4, 1920	
9. AGE last birthday		10. AGE last birthday		11. AGE last birthday		12. AGE last birthday	
35		35		35		35	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:			
Car Cleaner				Garage			
11. BIRTHPLACE (State or foreign country):				12. CITIZEN OF WHAT COUNTRY?			
Applae, Maryland				U. S. A.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Nathan White				Druscilla Carpenter			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
Yes WW-II				212 16-2921			
17. INFORMANT & ADDRESS:				18. MEDICAL CERTIFICATION			
Clin. Rec. Vet. Adm. Hosp. Fort Howard, Md.				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
156.1 IMMEDIATE CAUSE				UNKNOWN			
(A) CARCINOMA OF LIVER							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from Mar. 19, 1955, to Mar. 28, 1955, and that death occurred at 2:45 PM, from the causes and on the date stated above.		22. I hereby certify that I attended the deceased from Mar. 19, 1955, to Mar. 28, 1955, and that death occurred at 2:45 PM, from the causes and on the date stated above.		22. I hereby certify that I attended the deceased from Mar. 19, 1955, to Mar. 28, 1955, and that death occurred at 2:45 PM, from the causes and on the date stated above.		22. I hereby certify that I attended the deceased from Mar. 19, 1955, to Mar. 28, 1955, and that death occurred at 2:45 PM, from the causes and on the date stated above.	
SIGNATURE		ADDRESS		DATE SIGNED			
William B. VandeGrift, M. D.		M. D. VAH, Fort Howard, Md.		3-29-55			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		4-1-55		St. John's Methodist Cemetery		Calvert County, Maryland	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
3-30-55		[Signature]		Isaiah Brown & Son Funeral Home		108 W. Montgomery St., Baltimore, Md.	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

INSTRUCTIONS TO THE USER

COMPOSITE
BOX

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2483

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

02469

Reg. Dist. No. 43

1. PLACE OF DEATH COUNTY <u>Balto</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>X</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5 Greenwood Ave</u>		STREET ADDRESS (If rural, give location) <u>5 Greenwood Ave</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Robert D</u> (Middle) <u>Whiteford</u> (Last) <u>Whiteford</u>	4. DATE OF DEATH	(Month) <u>March</u> (Day) <u>8</u> (Year) <u>1955</u>
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widower</u>	8. DATE OF BIRTH <u>Aug 2-1874</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>maintenace man</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>Balto City Employee</u>	9. AGE last birthday <u>80</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>Balto City md</u>
13. FATHER'S NAME <u>George Whiteford</u>	14. MOTHER'S MAIDEN NAME <u>Mary</u>	12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>	16. SOCIAL SECURITY No. <u>NONE</u>	17. INFORMANT AND ADDRESS <u>Mrs Russell Huntington 5 Greenwood Ave</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>334 X</u> Immediate cause (a) <u>Cerebral arteriosclerosis</u> Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office hldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept</u> 19 <u>54</u> , to <u>March 8</u> 19 <u>55</u> , that I last saw the deceased alive on <u>March 4</u> 19 <u>55</u> , and that death occurred at <u>4 A</u> .m., from the causes and on the date stated above.			
SIGNATURE <u>Sily</u>		ADDRESS <u>H.A.</u> DATE SIGNED	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE THEREOF	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<u>Mar 9-1955 Mrs M. D. Reiskinder</u>		<u>Lassalun Funeral Home 7401 Belair Rd</u>	

Dr. Riglan

1 W Overton Ave

BUREAU V. S.

MAR 11 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2484

CERTIFICATE OF DEATH

Reg. Dist. No. 38

02470

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
X TOWN <u>Satyr Hill</u>				<u>Balto</u> 3Y01-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Shanklin Road</u>				STREET ADDRESS (If rural give location) <u>1142 Shanklin St</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>James C Whitlow</u>				DATE OF DEATH: <u>March 20, 1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>M</u>	8. DATE OF BIRTH: <u>Oct. 26, 1886</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Bookkeeper</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>England</u>		12. CITIZEN OF WHAT COUNTRY? <u>British</u>	
13. FATHER'S NAME: <u>Joseph Whitlow</u>				14. MOTHER'S MAIDEN NAME: <u>Katherine Clavel</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-18-8805</u>		17. INFORMANT & ADDRESS: <u>Sarahann Whitlow, Shanklin Rd Satyr Hill</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
158x IMMEDIATE CAUSE (A) <u>Carcinoid Carcinoma</u>						7 Days	
ANTECEDENT CAUSE (B) <u>Intestinal Obstruction</u>						2.15.55	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Gastric Neurosis</u>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		<u>Metastatic Ca of Liver Peritoneum</u>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory OF INJURY street, office bldg., etc)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>3/1</u> , 1955 to <u>3/20</u> , 1955 that I last saw the deceased alive on <u>3/20</u> , 1955, and that death occurred at <u>10⁰⁰</u> M, from the causes and on the date stated above.							
SIGNATURE <u>William J. Park</u>		M.D.		ADDRESS <u>700 N Charles</u>		DATE SIGNED <u>Feb 3. 1955</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>3/23/55</u>		NAME OF CEMETERY OR CREMATORY <u>Green Mount Cemetery, Baltimore, Md</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>3-21-55</u>		REGISTRAR'S SIGNATURE <u>J. H. H. H. H.</u>		24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>		ADDRESS <u>12128 Paul St</u>	

STATEMENT OF EXPENSES

FOR THE YEAR ENDING 1911

TO THE COMMISSIONER OF HEALTH
AND
THE BOARD OF HEALTH
OF THE CITY OF NEW YORK

IN RESPONSE TO RESOLUTION PASSED BY THE BOARD OF HEALTH
AT ITS MEETING HELD ON JANUARY 10, 1912

PREPARED BY THE COMMISSIONER OF HEALTH

AND THE BOARD OF HEALTH

OF THE CITY OF NEW YORK

FOR THE YEAR ENDING 1911

IN RESPONSE TO RESOLUTION PASSED BY THE BOARD OF HEALTH

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OF THE CITY OF NEW YORK

FOR THE YEAR ENDING 1911

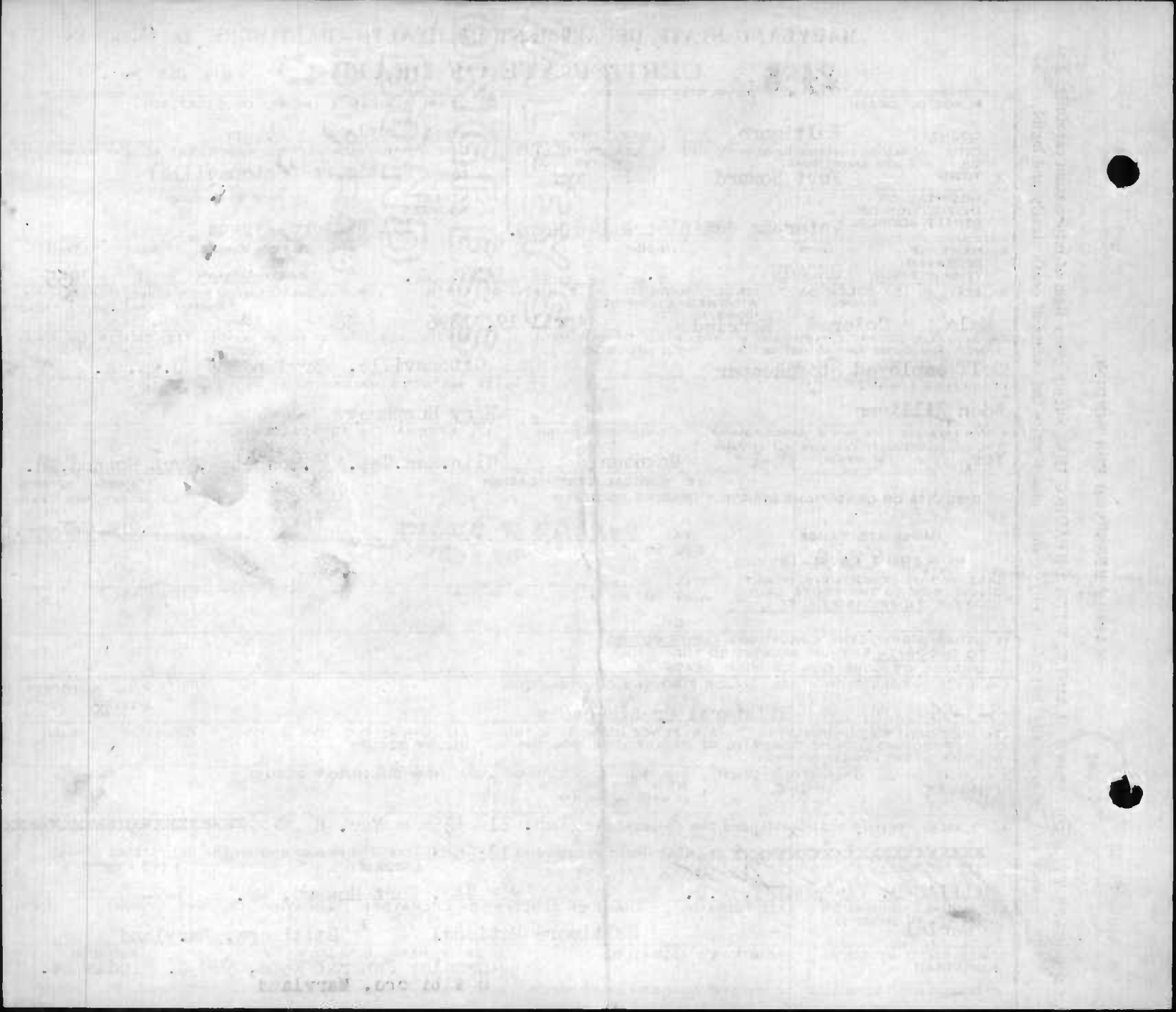
Reg. Dist. No.

PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Baltimore	STATE	Maryland
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Fort Howard	COUNTY	Baltimore (Catonsville)
TOWN	Fort Howard	STREET ADDRESS	151 Winters Avenue
HOSPITAL OR INSTITUTION OR STREET ADDRESS	Veterans Administration Hosp.		
3. NAME OF DECEASED: (Type or Print)	(First) GEORGE	(Middle) W.	(Last) WILLIAMS, SR.
4. DATE OF DEATH:	(Month) March	(Day) 8	(Year) 1955
5. SEX:	Male	6. COLOR OR RACE:	Colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	Married	8. DATE OF BIRTH:	April 19, 1896
9. AGE last birthday	58 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):	Self Employed Storekeeper
11. BIRTHPLACE (State or foreign country):	Catonsville, Maryland	12. CITIZEN OF WHAT COUNTRY?	U. S. A.
13. FATHER'S NAME:	Aden Williams	14. MOTHER'S MAIDEN NAME:	Mary Humphrey
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.): (If Yes, give war or dates of service)	Yes WW-I	16. SOCIAL SECURITY NO.	Unknown
17. INFORMANT & ADDRESS:	Clin. Rec. Vet. Adm. Hospital, Fort Howard, Md.		
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		UNKNOWN	
(A) IMMEDIATE CAUSE		CARCINOMA OF PROSTATE	
(B) ANTECEDENT CAUSE (S)		DUE TO	
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		DUE TO	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:	3-3-55	19B. MAJOR FINDINGS OF OPERATION	Bilateral Orchidectomy
20. AUTOPSY?	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	<input type="checkbox"/>	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	VA M.	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from Feb. 21, 1955, to Mar. 8, 1955, and that death occurred at 12:50 P.M. from the causes and on the date stated above.			
SIGNATURE		ADDRESS	
WILLIAM B. VANDEGRIFT, M.D.		M. O. VAH, Fort Howard, Md.	
DATE SIGNED		DATE SIGNED	
3-9-55		3-9-55	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	3-14-55	Baltimore National	Baltimore, Maryland
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
		Hemsley Funeral Home, 578 W. Biddle St.	Baltimore, Maryland

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



02472

MARYLAND 2486

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Owings Mills</u>	
X TOWN		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cover Road</u>		STREET ADDRESS (If rural, give location) <u>Cover Rd</u>	
3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
(First) <u>VERNON</u> (Middle) <u>LOUIS</u> (Last) <u>WILLIAMS</u>		(Month) <u>March</u> (Day) <u>21</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>July 30 1907</u>
9. AGE last birthday <u>47</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shipyard</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Rubin G. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Mary Harper</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY No. <u>213-18-1109</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Mary Williams Owings Mills Md</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
581.0 Immediate cause (a) <u>Coronary Thrombosis</u>				<u>1 hour</u>	
Antecedent cause(s) (b) <u>Cirrhosis, liver</u>				<u>1 year</u>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u></u>					
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

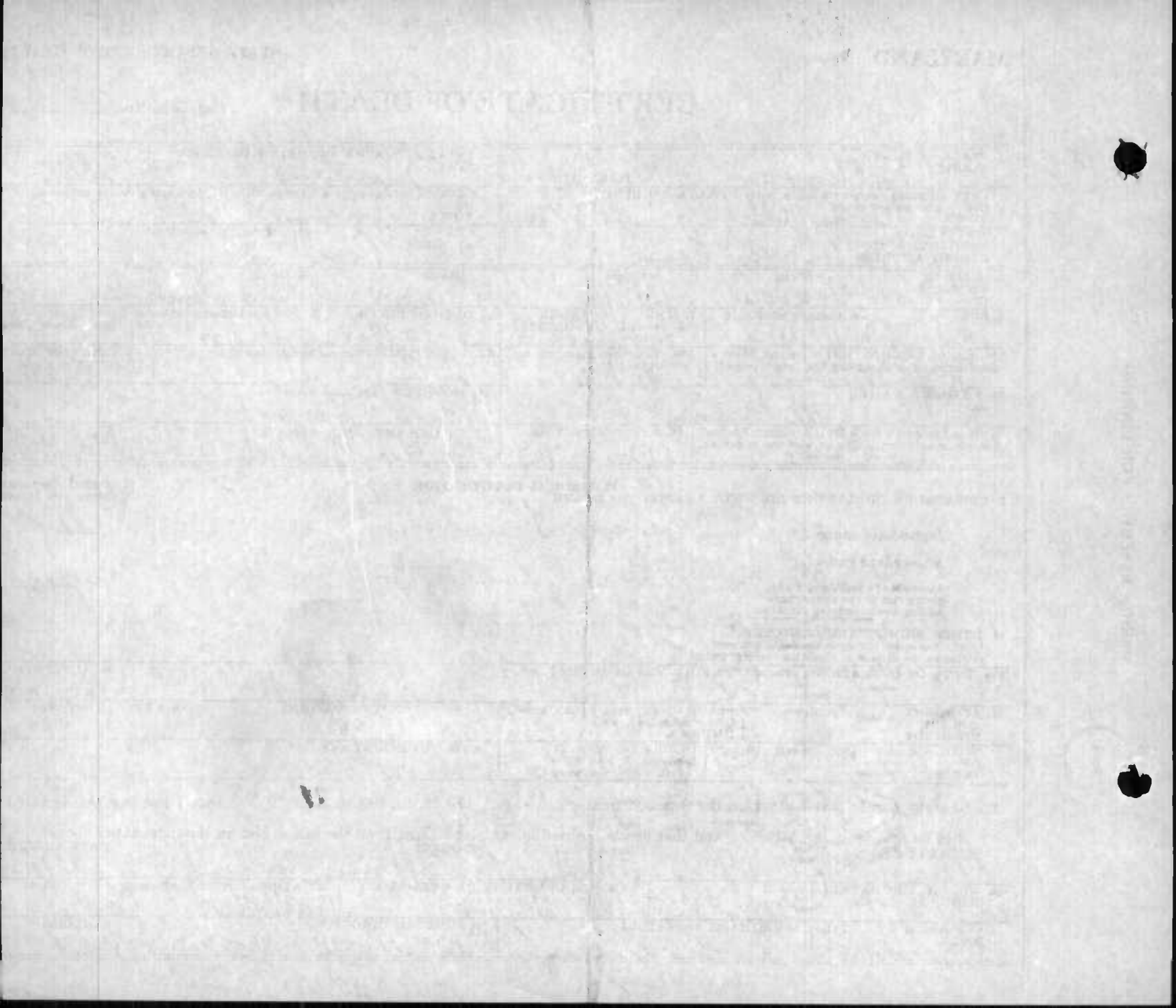
22. I hereby certify that I attended the deceased from Aug 23, 1954, to March 21, 1955, that I last saw the deceased alive on March 15, 1955, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

SIGNATURE Clarence E. McWilliams (Degree or title) ADDRESS Reisterstown, Maryland DATE SIGNED March 21, 1955

23. BURIAL, CREMATION REMOVAL (Specify) Burial DATE March 24-1955 NAME OF CEMETERY OR CREMATORY Calvary LOCATION (City, town, or county) Reisterstown, Md. (State)

DATE REC'D BY LOCAL REG. 3-23-55 REGISTRAR'S SIGNATURE R. H. Hedrick 24. FUNERAL DIRECTOR Burgess Funeral Home ADDRESS 23631 Fall Road
Horace F. Burgess

MARGIN RESERVED FOR BINDING



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

02473

2487

CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND				STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) X TOWN <u>Fort Howard</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> 3401-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 50 <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1705 1/2 Brunt St., Balto., Md.</u>			
3. NAME OF DECEASED: (Type or Print)		(First) <u>ROBERT</u>		(Middle) <u>(NMI)</u>		(Last) <u>WILLIS</u>	
4. DATE (Month) (Day) (Year) OF DEATH: <u>March 6,</u> <u>1955</u>							
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>5/2/95</u>	9. AGE last birthday <u>59</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Laborer</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Charles City Co., Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>
13. FATHER'S NAME: <u>Joseph Willis</u>				14. MOTHER'S MAIDEN NAME: <u>Mirah MN: Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WWI</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>443X</u>							UNKNOWN
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>1-20-55</u>		19B. MAJOR FINDINGS OF OPERATION <u>A.R. Amputation, left leg. Findings. 1. Dry gangrene, left lower leg. 2. Occlusion of popliteal artery</u>					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec. 26, 1954</u> to <u>Mar. 6, 1955</u> , and that death occurred at <u>9:15</u> M, from the causes and on the date stated above. SIGNATURE <u>William B. Vandegrift</u> ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3/10/55</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3-10-55</u>		REGISTRAR'S SIGNATURE <u>A W Hedrick</u>		24. FUNERAL DIRECTOR ADDRESS <u>Arlington S. Phillips Funeral Home</u> <u>1808 N. Monroe St., Balto., Maryland</u>			

CERTIFICATE OF DEATH

1911

STATE OF NEW YORK

County of ...

City of ...

On the ... day of ...

at ...

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2488

CERTIFICATE OF DEATH

Reg. Dist. No. 35

02474

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR TOWN <u>White Hall (Rural)</u>)		LENGTH OF STAY (in this place) <u>40 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>White Hall, (Rural)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Draystone Rd.</u>				STREET ADDRESS (If rural give location) <u>Draystone</u>			
3. NAME OF DECEASED: (First) <u>Delie</u> (Middle) <u>Myrtle</u> (Last) <u>Wilson</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar.</u> <u>10</u> <u>19 55</u>			
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>3-16-1894</u>	9. AGE last birthday <u>60</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Spring Mfg. Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Samuel Hoover</u>				14. MOTHER'S MAIDEN NAME: <u>Elsie Coe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>216-24-8317</u>		17. INFORMANT & ADDRESS: <u>Wm. Leonard Wilson, White Hall, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>						<u>15 MIN.</u>	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1945</u> , to <u>3/10</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>3/9</u> , 19 <u>55</u> , and that death occurred at <u>1 A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>C. M. France</u>				M. D. <u>Barnton, Md.</u>		DATE SIGNED <u>3/10/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>3-17-55</u>		NAME OF CEMETERY, OR CREMATORY <u>West Liberty Methodist</u>		LOCATION (City, town, or county) (State) <u>White Hall, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>3/12/55</u>		REGISTRAR'S SIGNATURE <u>Mrs. Howard S. Maxwell</u>		24. FUNERAL DIRECTOR <u>Brooks Funeral Service, Sparks, Md.</u>		ADDRESS	

RECEIVED

MAR 15 1955

BUREAU V. 3

02475

MARYLAND 2489

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH COUNTY Baltimore		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town) Glyndon		CITY (If outside corporate limits, write RURAL and give nearest town) Glyndon	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sacred Heart Lane		STREET ADDRESS (If rural, give location) Sacred Heart Lane	
3. NAME OF DECEASED (Type or Print) Pearl		4. DATE OF DEATH March 28, 1955	
5. SEX Female		6. COLOR OR RACE Colored	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married		8. DATE OF BIRTH April 10, 1881	
9. AGE last birthday 73 yrs.		10. AGE last birthday 73 yrs.	
11. BIRTH PLACE (State or foreign country) Baltimore County		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME James Neal		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) No		16. SOCIAL SECURITY No. None	
17. INFORMANT AND ADDRESS Russell Wimple, Glyndon, Md.			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<p>420.1 Immediate cause (a) Coronary Thrombosis</p> <p>Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) Arteriosclerotic C.V. Disease</p>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		

19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from June, 1948, to March 28, 1955, that I last saw the deceased

alive on March 28, 1955, and that death occurred at 11:00 P.m., from the causes and on the date stated above.

SIGNATURE Martin E. Strobel (Degree or title) M.D. ADDRESS Reisterstown, Md. DATE SIGNED 3/29/55

23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE April 1, 1955		NAME OF CEMETERY OR CREMATORY Piney Grove		LOCATION (City, town, or county) Baltimore County	
DATE REC'D BY LOCAL REG. 3-30-55		REGISTRAR'S SIGNATURE Mary B. Eline		24. FUNERAL DIRECTOR J.F. Eline & Sons		ADDRESS Reisterstown, Md.	

MARGIN RESERVED FOR BINDING

BUREAU V. S.

APR 1 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2319

CERTIFICATE OF DEATH

Reg. Dist. No.

02476

41

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Dundalk</u> TOWN <u>Dundalk</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Dundalk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1531 Leslie Ave.</u>		STREET ADDRESS (If rural give location) <u>1531 Leslie Ave.</u>	

3. NAME OF DECEASED: (Type or Print) <u>ISABEL E. WOOLFORD</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>Mar. 4,</u> <u>19 55</u>		
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH: <u>Sept. 30, 1917</u>	9. AGE last birthday <u>37</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Md.</u>	
13. FATHER'S NAME: <u>Frederick W. Hippler</u>			14. MOTHER'S MAIDEN NAME: <u>Blanche Innerst</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS: <u>Mr. Dixon R. Woolford-1531 Leslie Ave.</u>	

18. MEDICAL CERTIFICATION I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>744.1</u> IMMEDIATE CAUSE ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(A) <u>Aspiration Pneumonia</u> DUE TO (B) <u>Progressive Muscular Dystrophy</u> DUE TO (C)		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>16 years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July, 1952, to March, 1955, that I last saw the deceased alive on March 3, 1955, and that death occurred at 7 a M, from the causes and on the date stated above.

SIGNATURE John H. Collins Harvey ADDRESS M.D. 410 Kottbus DATE SIGNED March 3, 1955

23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial DATE THEREOF 3/8/55 NAME OF CEMETERY OR CREMATORY Loudon Park Cem. LOCATION (City, town, or county) Balto., Md. (State)

DATE REC'D BY LOCAL REGISTRAR <u>3-7-55</u>	REGISTRAR'S SIGNATURE <u>CL</u>	24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Lickner & Sons</u> ADDRESS <u>Balto 1744</u>
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MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

